STATE OF MAINE

WORKERS' COMPENSATION BOARD

OFFICE OF MONITORING, AUDIT AND ENFORCEMENT

FORMS AND PETITIONS MANUAL

June 2011

Compiled and issued by the Maine Workers' Compensation Board (Board). Printed under appropriation number 014 90C 2005 012.

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TABLE OF CONTENTS

STATE OF MAINE
WORKERS' COMPENSATION BOARD

CENTRAL OFFICE

27 State House Station
Augusta, Maine 04333-0027
1-888-801-9087

TTY (207) 287-6119
FAX (207) 287-7198
FAX (**for Claims Management forms only)** (207) 287-5895

Abuse Investigation Unit	(207) 287-7065
Central Office - General Number	(207) 287-3751
Claims Management Unit	(207) 287-2002
Insurance Coverage Unit	(207) 287-7092
Office of Monitoring, Audit and Enforcement	(207) 287-7067

REGIONAL OFFICES

AUGUSTA
24 Stone Street, Suite 2
Augusta, Maine 04330-5220
(207) 287-2308
1-800-400-6854

BANGOR
106 Hogan Road
Bangor, Maine 04401-5640
(207) 941-4550
1-800-400-6856

CARIBOU
One Vaughn Place
43 Hatch Drive, Suite 110
Caribou, Maine 04736-2347
(207) 498-6428
1-800-400-6855

LEWISTON
36 Mollison Way
Lewiston, Maine 04240-5811
(207) 753-7700
1-800-400-6857

PORTLAND
62 Elm Street
Portland, Maine 04101-3061
(207) 822-0840
1-800-400-6858

RESOURCES OFFERED BY THE MAINE WORKERS' COMPENSATION BOARD

(Available from Central Office)
(Copy Fee Schedule may apply)

Maine Workers' Compensation Act of 1992, Title 39-A, M.R.S.A.

Maine Workers' Compensation Board Rules and Regulations

Maine Workers' Compensation Forms Manual

Maine Workers' Compensation Board 1993-2010 Weekly Benefit Tables

Maine Workers' Compensation Board Medical Fee Schedule

Facts About Maine's Workers' Compensation Laws (an employee pamphlet)

Training workshops presented by Board staff (call Office of Monitoring, Audit & Enforcement 287-7067)

Maine Workers' Compensation Board Forms (First Reports of Injury, Wage Statements, etc.)

MAINE WORKERS' COMPENSATION BOARD FORMS REFERENCE GUIDE

BOARD FORM	FORMS	SPECIFIC STATUTES	SPECIFIC REGULATIONS	GENERAL STATUTES	GENERAL REGULATIONS	FILING REQUIREMENTS
WCB-1	First Report of Injury	§303	1.7 3.1 3.4 8.13 8.16	§152 (10) §153 (4) §357 (1) §360 (1) (2)	15.9 (2) 15.10 (2)	Filed electronically within 7 days notice/knowledge of incapacity.
WCB-1A	Proof of Coverage		§152 (10) §153 (4) §357 (1) §360 (1) (2) §403 (1)	15.7 (2) 15.9 (2) 15.10 (2)		Filed electronically within 14 days of the start date of new and renewal policies.
WCB-2	Wage Statement	§153 (4) §205 (8) §303	1.7	§152 (10) §153 (4) §357 (1) §360 (1) (2)	15.9 (2) 15.10 (2)	Filed within 30 days notice/knowledge of a claim for compensation.
WCB-2A	Schedule of Dependents and Filing Status Statement		1.7 8.9	§102 (1) §152 910) §153 (4) §205 (8) §303 §357 §360 (1) (2)	15.9 (2) 15.10 (2)	Filed within 30 days notice/knowledge of a claim for compensation.
WCB-3	Memorandum of Payment	§153 (1) (B) §205(7)(A)(B)(C)(D)	1.1 (A) (B) 1.1 (3) 1.7 8.12	§152 (10) §153 (4) §357 (1) §360 (1) (2)	15.9 (2) 15.10 (2)	Filed within 14 days notice/knowledge of incapacity.
WCB-4	Discontinuance or Modification of Compensation		1.7 8.11 8.12	§152 (10) §153 (4) §205 (9)(A) §357 (1) §360 (1) (2)	15.9 15.1	
WCB-4A	Consent Between Employer and Employee		8.18			
WCB-6	Certificate Authorizing Release of Benefits Information	§221 (5)		§360 (1)(2)	15.9 (2) 15.10 (2)	
WCB-8	Certificate of Discontinuance or Reductiuon of Compensation	§205 (9) (B) (1)	1.7 8.15	§152 (10) §153 (4) §357 (1) §360 (1) (2)	15.9 (2) 15.10 (2)	
WCB-9	Notice of Controversy	§313 (1)	1.1 (C) 1.7 3.4 8.2 8.12	§152 (10) §153 (4) §357 (1) §360 (1) (2)	15.9 (2) 15.10 (2)	Filed electronically within 14 days notice/knowledge of incapacity.
WCB-10	Lump Sum Setlement		1.7	§352 (1) §153 (4) §357 (1) §360 (1) (2)	12.6 (1) (2) 15.9 (2) 15.10 (2)	
WCB-11	Statement of Compensation Paid		1.7 8.1 8.12	§152 (10) §153 (4) §357 (1) §360 (1) (2)	15.9 (2) 15.10 (2)	Filed within 6 months from the date of injury when indemnity benefits are paid and annually on the anniversary date of the injury subsequent to that. Final report filed when no further benefits are anticipated.
WCB-220	Limited Certificate Authorizing Written Release of Medical/Health Care Information		12.18 (1)	§208 (1)	12.18 (2)	
WCB-230	Employment Status Report	§308 (2)	1.8			
WCB-231	Employee's Return to Work Report	§308 (1)	1.7 8.17			
WCB-231A	Employee's Return to Work Report	§205 (9)(B) §308 (1)	1.7 8.15			
WCB-250	Request for Expedited Proceeding		1.9	§205 (9) (E) §315		

MAINE WORKERS' COMPENSATION BOARD PENALTIES REFERENCE GUIDE

VIOLATION	SPECIFIC STATUTES	SPECIFIC REGULATIONS	GENERAL STATUTES	GENERAL REGULATIONS	PENALTIES	
					PAID TO	CRITERIA
Conduct at mediation	313(4)(5)	15.5	313(2)		A) Varies	A) The board may impose sanctions against a party who does not cooperate or produce requested materials (includes failure to attend a scheduled mediation).
					B) Workers' Compensation Board Administrative Fund	B) The board may assess a forfeiture in the amount of $100 against any employer or representative of the employee, employer or insurer who participates in mediation without full authority to make decisions regarding the claim.
Delay in payment of benefits	205(3)	15.3(1)(2)(3)	152.10 205(1)(2)	1.1(5) 8.4	Worker	When there is not an ongoing dispute, if weekly compensation benefits or accrued weekly benefits are not paid within 30 days after becoming due and payable, $50 per day must be added and paid to the worker for each day over 30 days in which the benefits are not paid. Not more than $1,500 in total may be added pursuant to this subsection.
Delay in payment of medical bills	205(4)	15.3(1)(4)(5)	206	5.7(2) 7.3(8)	Provider or Employee	When there is no ongoing dispute, if bills for medical or health care services are not paid within 30 days after the carrier has received notice of nonpayment by certified mail, $50 or the amount of the bill due, whichever is less, must be added and paid to the provider of the medical or health care services or to the employee who paid for the medical or health care services for each day over 30 days in which the bills are not paid. Not more than $1,500 in total may be added pursuant to this subsection.
Failure to file form or to file form timely	360(1)	15.9	153.4 357.1	1.1(1)(3)(5) 1.7 8.1 8.11 8.12 8.13 8.16 8.18(1)	General Fund	The board may assess a civil penalty not to exceed $100 for each violation on any person who fails to file or complete any report or form required by this Act or rules adopted under this act; or who fails to file or complete such a report or form within the time limits specified in this Act or rules adopted under this Act.
Failure to file medical report	208(2)(A)	5.19(1)	207		Workers' Compensation Board Administrative Fund	Except for claims for medical benefits only, within 5 business days from the completion of a medical examination or within 5 business days from the date notice of injury is given to the employer, whichever is later, the health care provider treating the employee shall forward to the employer and the employee a diagnostic medical report, on forms prescribed by the board, for the injury for which compensation is being claimed. The board may assess penalties up to $500 per violation on health care providers who fail to comply with the 5-day requirement.

Failure to pay assessment	154(8)		154		Workers' Compensation Board Administrative Fund	Any insurance company, association or self-insured employer subject to an assessment that willfully fails to pay, commits a civil violation for which a forfeiture of not more than $500 may be adjudged for each day following the due date for which payment is not made.
Failure to pay compensation	324(2)	15.6	324(1)	8.6 8.18(2)	A) Of each day's fine amount, the first $50 is paid to the employee to whom compensation is due. The remainder must be paid to the Workers' Compensation Board Administrative Fund	A) If an employer or insurance carrier fails to pay compensation within 10 days receipt of board decree or approved agreement, the board may assess against the employer or insurance carrier a fine of up to $200 for each day of noncompliance.
					B) Employee	B) If a fine is assessed against any employer or insurance carrier on petition by an employee, the employer or insurance carrier shall pay reasonable costs and attorney's fees related to the fine, as determined by the board.
Fraud or willful violation	360(2)	15.10	153(5)(B)(E)	1.1(1)(2)(3)(5) 1.5 8	General Fund	The board may assess, after hearing, a civil penalty in an amount not to exceed $1,000 for an individual and $10,000 for a corporation, partnership or other legal entity for any willful violation of this Act, fraud or intentional misrepresentation.
Pattern of questionable claims handling techniques	359(2)	15.8	153(5)(B)(E)	1.1(1)(2)(3)(5) 1.5 8	General Fund	In addition to any other penalty assessment permitted under this Act, the board may assess civil penalties not to exceed $25,000 upon finding, after hearing, that an employer, insurer, or 3rd-party administrator for an employer has engaged in a pattern of questionable claims-handling techniques or repeated unreasonably contested claims.

EFFECTIVE DATES OF SIGNIFICANT CHANGES IN THE WORKERS' COMPENSATION ACT

Subject	Statute (39 M.R.S.A.)	P.L.	Eff. Date
66-2/3% ceiling	54, 55, 58	65, c. 408	11/30/65
PI of back, neck, etc.	56-A	71, c. 465	09/23/71
PI increase	56	71, c. 318	09/23/71
Partial disability-325 weeks	55	71, c. 386	09/23/71
Inflation protection	54, 55, 58	71, c. 225	01/01/72
"By accident" deleted	52	73, c. 289	10/03/73
PI scarring $5M to $7.5M	56	73, c. 392	10/03/73
Partial disability-unlimited	55	73, c. 531	11/30/73
Mandatory law	51	73, c. 746	06/28/74
Waiting period (7 to 3)	53	73, c. 557	11/29/74
100% ceiling	54, 55, 58	73, c. 788	12/01/74
133-1/3% ceiling	54, 55, 58	75, c. 493[1]	07/01/77
166-2/3% ceiling	54, 55, 58	75, c. 493[1]	07/01/79
200% ceiling	54, 55, 58	75, c. 493[1]	07/01/81
Unemployment set-off	62-A	79, c. 496	09/14/79[2]
Repeal of 200% ceiling to 166-2/3%	54, 55, 58	81, c. 483[3]	06/22/81
Inflation on anniversary	54, 55, 58	83, c. 479	07/01/83[4]
Chiropractic services expanded	52	83, c. 158	09/23/83[2]
Independent contractor	2(5) (A) (2)	83, c. 402	09/23/83
Early pay-informal conference	51-B, 94-B	83, c. 479	01/01/84
No attorney fees until one week post informal conference	110	83, c. 479	01/01/84
Maximum benefit frozen at $447.92 until 7/1/88	53-A	85, c. 372	06/30/85[5]
5% inflation cap	54-A, 55-A, 58-A	85, c. 372	06/30/85[5]
PI based on SAWW	56, 56-A	85, c. 372	06/30/85[5]
S.S. coordination of benefits	62-B	85, c. 372	06/30/85[5]
Attorney fees/prevail only	103-B, 103-C, 110	85, c. 372	06/30/85[5]
Mini-Miranda rule changed	112, 112-A	85, c. 372	06/30/85[5]
New discrimination remedies	111	85, c. 118	09/19/85
Agriculture exemption (4-6)	2, 4, 21-A	85, c. 249	09/19/85
Vocational rehabilitation	66-A, 81, 90	85, c. 372	01/01/86[5]
Maximum benefit freeze at $447.92 extended to 8/1/88	53-A	87, c. 156	06/30/85[5]
Mental stress limited	51(3)	87, c. 252	09/29/87[2]
Annual adjustments – 3rd anniversary	54-B	87, c. 559	11/20/87[5]

EFFECTIVE DATES OF SIGNIFICANT CHANGES IN THE WORKERS' COMPENSATION ACT

Subject	Statute (39 M.R.S.A.)	P.L.	Eff. Date
Total incapacity/MMI/full-time work ability	54-B	87, c. 559	11/20/87[5]
Partial incapacity/400-week limitation from MMI	55-B	87, c. 559	11/20/87[5]
Permanent impairment/whole man Ratings	56-B	87, c. 559	11/20/87[5]
Provisional suspension orders	100(4)	87, c. 559	11/20/87[5]
New rehabilitation program		89, c. 580	11/20/87[5]
Partial incapacity limited to 520 weeks of benefits, including total	55-B	91, c. 615	10/17/91[5]
Office of Medical Coordination	122	91, c. 615	10/17/91[5]
Independent Medical Examiner	92-A	91, c. 615	10/17/91[5]
Automatic discontinuance or reduction	100-4A	91, c. 615	10/17/91[5]
Permanent impairment benefits reduced by amount of total and partial benefits	56-b	91, C. 615	10/17/91[5]

1. Bernard v. Cives, 395 A.2d, 1141 (Me. 1978) eff. for injuries on or after 10/01/75 each ceiling increase is phased in at two-year intervals.

2. Legislation does not specify whether provision is effective for new injuries only.

3. Terry v. St. Regis, 459 A.2d, 1106 (Me. 1983) 200% maximum still applies for injuries between 10/01/75 and 06/21/81.

4. Injuries prior to this date receive adjustment annually on July 1st.

5. Injuries on or after this date.

NOTES

EMPLOYER'S FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE

(Note: the DN Numbers represent a crosswalk to the IAIABC Claims Release 3 EDI data elements.)

1. WCB FILE NUMBER (if known): **DN5**

1a. OSHA 300 CASE NUMBER (if applicable): NA

REASON FOR REPORT (check all that apply)

2a. ☐ LOST TIME - ONE OR MORE DAYS **DN74** 2b. WAS EMPLOYEE PAID FOR ½ DAY OR MORE ON DAY OF INJURY? ☐ YES ☐ NO NA

3. ☐ LOST EARNINGS BUT NO LOST TIME NA 4. ☐ MEDICAL/HEALTH CARE **DN74** 5. ☐ FATALITY DATE OF DEATH: ____/____/____ **DN57**
Also see DN146 MM DD YYYY

6a. ☐ OCCUPATIONAL DISEASE **DN290** 6b. DATE OF LAST EXPOSURE: ____/____/____ **DN31** MM DD YYYY 6c. DATE OF DIAGNOSIS AS OCCUPATIONALLY RELATED: ____/____/____ NA MM DD YYYY

7a. ☐ CORRECT PRIOR REPORT **DN2** 7b. DATE OF CORRECTION: ____/____/____ **DN3** MM DD YYYY 7c. DATE CORRECTION SENT TO WCB: ____/____/____ **DN3** MM DD YYYY
Note: also see correction process & DN295, 296

8. STATE EMPLOYER UNEMPLOYMENT INSURANCE ACCOUNT NUMBER (UIAN): **DN329**	9. FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN): **DN16**		10. EMPLOYER NAME: **DN18**	
11. STREET/P.O BOX MAILING ADDRESS: **DN168-169**	12. CITY: **DN165**	13. STATE: **DN170**	14. ZIP: **DN167**	15. TELEPHONE NUMBER: **DN159** ( )
16. PRIMARY BUSINESS PERFORMED BY EMPLOYER WHERE INJURY OCCURRED: **DN25**	17. EMPLOYER LOCATION IF DIFFERENT FROM MAILING ADDRESS: **DN19-23** EMPLOYER PHYSICAL COUNTRY CODE = **DN164**		18. DID INJURY OR EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO **DN249** IF NO, THEN GIVE NAME AND PHYSICAL ADDRESS OF THE EMPLOYER WHERE THE EMPLOYEE WAS INJURED OR EXPOSED: **DN120; 119, 122, 121, 123, 33, 118** ACCIDENT SITE COUNTRY CODE = **DN280**	

(check one) ☐ INSURER ☐ THIRD PARTY ADMINISTRATOR (TPA) ☐ SELF-ADMINISTERED EMPLOYER

19. INSURANCE / TPA COMPANY NAME: **DN7/188**	20. POLICY NUMBER: **DN28**		21. INSURER FILE NUMBER: **DN15**	
22. STREET/P.O. BOX MAILING ADDRESS: **DN10-11**	23. CITY: **DN12**	24. STATE: **DN13**	25. ZIP: **DN14**	26. TELEPHONE NUMBER: ( ) NA

27. LAST NAME: **DN43 & DN255**	28. FIRST NAME: **DN44**	29. MI: **DN45**	30. TELEPHONE NUMBER: ( ) **DN51**	31. SOCIAL SECURITY NUMBER: **DN42**	32. GENDER: **DN53** ☐ MALE ☐ FEMALE
33. STREET/P.O. BOX MAILING ADDRESS: **DN46-47**	34. CITY: **DN48**		35. STATE: **DN49**	36. ZIP: **DN50**	37. DATE OF BIRTH: **DN52** ____/____/____ MM DD YYYY
38. OCCUPATION/JOB TITLE: **DN60**	39. DATE OF HIRE: **DN61** ____/____/____ MM DD YYYY	40. WEEKLY WAGE AT TIME OF INJURY: $ **DN62**		41. DOES EMPLOYEE WORK FOR ANOTHER EMPLOYER? ☐YES ☐ NO IF YES, GIVE NAME AND ADDRESS: NA	

42. DATE OF INJURY OR ILLNESS: ____/____/____ **DN31** MM DD YYYY DATE EMPLOYER NOTIFIED: ____/____/____ **DN40** MM DD YYYY	43. DATE OF INCAPACITY: ____/____/____ **DN56** MM DD YYYY DATE EMPLOYER NOTIFIED: ____/____/____ **DN281** MM DD YYYY	44. TIME EMPLOYEE BEGAN WORK (e.g. 7:30 a.m.): NA 46. TIME OF INJURY (e.g. 1:10 p.m.): **DN32**	45. DATE EMPLOYER NOTIFIED INSURER/TPA: ____/____/____ **DN41** MM DD YYYY 47. HAS EMPLOYEE RETURNED TO WORK? ☐ YES ☐ NO **DN 189** IF YES, GIVE DATE: ____/____/____ **DN68** MM DD YYYY

48. SPECIFIC INJURY OR ILLNESS (e.g. second degree burn or toxic hepatitis): **DN35**	49. BODY PART(s) AFFECTED (e.g. lower right forearm): **DN36**	50. ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN THE EVENT OCCURRED (e.g. acetylene torch, metal plate): **DN37**

51. SPECIFY ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE EVENT OCCURRED (e.g. cutting metal plate for flooring.): NA	52. HOW INJURY OR ILLNESS OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED OR MADE THE EMPLOYEE ILL. (e.g. worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against hot metal.): **DN38**

53. HOSPITALIZED OVERNIGHT AS INPATIENT? ☐ YES ☐ NO NA	54. WAS THE EMPLOYEE TREATED IN AN EMERGENCY ROOM? ☐ YES ☐ NO: NA	55. HEALTH CARE PROVICER NAME: NA	56. MAILING ADDRESS: NA	57. TELEPHONE NUMBER: ( ) NA

58. PREPARER NAME AND TITLE (TYPE OR PRINT): NA	59. TELEPHONE NUMBER: ( ) NA	60. DATE SENT TO WCB: **DN100** ____/____/____ MM DD YYYY

WCB-1 (01/02) The State of Maine does not discriminate on the basis of disability in admission to, access to, or operation of its programs, services or activities. This material can be made available in alternate formats by contacting your Department ADA Coordinator.
DISTRIBUTION: COPY (1) MAINE WORKERS' COMPENSATION BOARD, 27 STATE HOUSE STATION, AUGUSTA, MAINE 04333-0027, (2) EMPLOYEE, (3) INSURER, (4) EMPLOYER.

EMPLOYER'S FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE, WCB-1

General Reporting Requirements

The employer or insurer (which can sometimes be one and the same) must file* a First Report (FROI) to report an employee injury that has caused the employee to lose a day's work. See §303.

The definition of a day for the purposes of filing a FROI under §303 is the wages in an employee's regular workday. "Wages in an employee's regular workday" is the amount equivalent to a day's wages for those who earn the same amount each workday, regardless of the duration of such person's employment. For all others, "wages in an employee's regular workday" is determined by dividing the pre-tax wages earned by the employer during the four (4) full work week period immediately preceding the date of injury by the number of days worked during the same four (4) full work week period. In the event that an employee has worked for less that the four (4) full work week period preceding the date of injury, "wages in an employee's regular workday" is determined by dividing the pre-tax wages earned by the number of days worked. See Rule 3.1.

Lost Wages: The FROI must be filed* within seven (7) days after the employer's notice or knowledge that an employee has actually lost wages in an amount equivalent to that sum which would have been earned in a regular workday.

Lost Time: If the employee has physical limitations due to the injury and loses consecutive hours equal to a regular workday because the employer cannot accommodate those restrictions, a FROI must be filed* within seven (7) days after an employer's notice or knowledge that an employee has actually lost hours equal to a regular workday regardless of actual wage loss.

When an employee loses a day or more from work that does not result in the filing of a Memorandum of Payment or a Notice of Controversy, the employer or insurer shall notify the Board of the employee's return to work date, if the date was not included on the original First Report, by filing* an 02 First Report using the IAIABC Claims Release 3 format. The employee's return to work date shall be filed within seven (7) days of the employee's return to work. See Rule 8.16.

Death: If the employee dies as a result of a job-related injury or if the employee dies at the work site, regardless of the reason for death, the employer or insurer must file* a FROI.

Medical Only: The employer or insurer must complete a FROI within seven (7) days of notice or knowledge of an employee injury that requires the services of a health care provider, but there

* accepted EDI transaction, with or without errors ("TE" or "TA" only)

is no obligation to file it with the Board unless the injury later causes the employee to lose a day's work. If the employer or insurer disputes a medical bill on a claim for which a FROI was never filed, the employer or insurer must file* the FROI.

Two Injuries on Same Day at Same Employer: In the event that an employee alleges two separate injuries on the same date while working for the same employer, only one FROI may be filed via EDI. The other FROI must be sent to the Board (in accordance with the guidelines established above) via e-mail, via fax (207-287-5895), or via standard mail at the following address:

Workers' Compensation Board
27 State House Station
Augusta, ME 04333-0027

Please call 207-287-7197 before sending the paper FROI so that it does not get rejected.

EDI Reporting Requirements

Unless a waiver has been granted, effective July 1, 2005, all FROIs (see above exception for two injuries on same day at same employer) shall be filed* using the International Association of Industrial Accident Boards and Commissions (IAIABC) Claims Release 3 format. See Rule 3.4. Following is a general overview. More detailed information can be found at: http://www.state.me.us/wcb/departments/technology/electronic.htm.

Each transaction requires a Maintenance Type Code (MTC/DN0002). MTC/DN0002 is a code that identifies the type of FROI transaction:

MTC	Definition
00	Original: The original/initial FROI, including the re-transmission of a FROI that was rejected due to a critical error, or a FROI that was previously cancelled.
01	Cancel: Cancel/delete FROI from the Board's system. The original/initial FROI was sent in error. The jurisdiction claim number/WCBN is mandatory for this transaction.
02	Change/Update: Change/update FROI. The jurisdiction claim number/WCBN is mandatory for this transaction.
CO	Correction: Correct transaction reported on the AKC as "TE" (see below). This transaction must contain the Maintenance Type Correction Code (MTCC) and Maintenance Type Correction Code Date (MTCC Date) fields. These fields communicate which report is being corrected. The jurisdiction claim number/WCBN is mandatory for this transaction.
04	Full Denial: A FROI 04 transaction indicates an original/new FROI and the filing of a Full Denial simultaneously. This MTC can only be used if the FROI has never been filed with the Board.
AQ	Acquired Claim: Report that a new claim administrator has acquired the claim. The jurisdiction claim number/WCBN is mandatory for this transaction.
AU	Acquired/Unallocated Claim: The equivalent of a FROI 00 filed by new claim administrator.
UR	Upon Request: Submitted in response to a specific request. If the Board receives a subsequent report of injury (MOP, Petition) for an employee for a date of injury that is not in the Board's system, a letter will be sent to the claim administrator requesting that a FROI UR be sent. There is no other circumstance in which a FROI UR should be sent to the Board. The jurisdiction claim number/WCBN is mandatory for this transaction.

* accepted EDI transaction, with or without errors ("TE" or "TA" only)

Each transaction requires a Claim Type Code (DN0074). DN0074 is a code representing the current classification of the claim:

DN0074	Definition
M	Medical Only.
I	Lost Time/Indemnity.
N	Notification Only.
B	Became Medical Only.
L	Became Lost Time/Indemnity.

Each transaction is acknowledged with an Application Acknowledgement Code (DN0111) used to identify the accepted/rejected status of the transaction being acknowledged:

DN0111	Definition
HD	Batch Rejected: Batch rejected in its entirety.
TA	Transaction Accepted: The transaction was accepted without errors.
TE	Transaction Accepted with Error: An error was found on an expected data element. A CO (Correction) must be submitted to resolve the error(s).
TN	Transaction Rejected by Service Provider: The transaction fails mandatory requirements.
TR	Transaction Rejected: The transaction was not accepted. An error was found on a mandatory or mandatory conditional data element. A review of the error(s) must take place to determine if the transaction should be resubmitted with the same MTC – correcting the error. If an error of duplicate transaction, invalid event sequence, etc. then resubmission may not be required.

It is the claim administrator's responsibility to maintain the Acknowledgment (AKC) for every batch of EDI transactions sent to the Board. A FROI is not considered filed with the Board until it receives a "TA" or "TE" code on the AKC.

Corrections

Changes and corrections to FROIs must be filed* via EDI. Please note the important difference between a change (MTC "02") and a correction (MTC "CO"), as outlined above.

* accepted EDI transaction, with or without errors ("TE" or "TA" only)

Distribution
WCB-1 (1/02) shall be mailed to the employee and the employer within 24 hours after the FROI is sent to the Board.

Closure (required for all lost time FROIs)
Closure of the FROI is required if a FROI is or should have been filed with the Board under §303. See Rule 8.16. Closure occurs when one of the following actions is taken:

1) Return to Work: Where days lost is less than or equal to 7 days, the actual return-to-work date must be reported to the Board within 7 days of the employee's return to work by sending a FROI 02 transaction. This step is unnecessary if the actual return-to-work date was previously reported on the original/initial FROI.

2) Indemnity Payment: Where the initial claim for indemnity benefits is paid, a Memorandum of Payment must be sent to the Board on or before the 14th day payment is due under §205(2) and must be received at the Board by the 17th day (three mail days are provided for receipt by the Board where sent via standard mail).

3) Controversy: Where the initial claim for indemnity benefits is in dispute, a Notice of Controversy must be filed* on or before the 14th day payment is due under §205(2).

Form Filing Violations
Failure to file any Board-prescribed forms within established time frames is a violation under §360(1). Violations may result in the filing of complaints with the Abuse Investigation Unit. The Abuse Investigation Unit will process complaints in the manner set forth in Rule 15.9.

INSTRUCTIONS FOR COMPLETING EMPLOYER'S FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE, WCB-1

For instructional purposes, this Forms Manual indicates the WCB-1 Box # and description as listed on the paper form, the IAIABC Data Element Number (DN) and the data requirements of each field to assist claim administrators with electronic filing and paper distribution of FROIs. Specific technical questions can be answered by reviewing the Element Requirement Tables that are available at: http://www.state.me.us/wcb/departments/technology/edirule.htm.

Certain fields are mandatory at the time of the EDI transaction. If any "mandatory" fields are missing, incomplete or incorrect, the EDI transaction will completely reject, resulting in a "TR" on the AKC. A "TR" on the AKC means that the EDI transaction was completely rejected. The fatal error(s) that caused the rejection must be corrected and a new EDI transaction must be sent as if it had never sent it in before. Other fields are given an expected rating which indicates that the data in those fields is expected by the Board. If any "expected" fields are missing, incomplete or incorrect, the FROI will be accepted (filed) with errors. The error(s) must be corrected by submitting a MTC "CO" using the jurisdiction claim number/WCBN provided in the acknowledgement report.

* accepted EDI transaction, with or without errors ("TE" or "TA" only)

1. WCB File Number (if known): **(Assigned for FROI 00, FROI 04, and FROI AU; Mandatory for FROI 01, FROI 02, FROI CO, FROI AQ and FROI UR) (DN5 – JURISDICTION CLAIM NUMBER)**
   Enter the file number assigned by the Board to identify this claim**.**

1a. OSHA 300 Case Number (if applicable): **(Not on the IAIABC format).**

2a. ☐ Lost Time - One or More Days

Check this box if the employee has lost a day or more **(DN74 - CLAIM TYPE CODE = I or L)**. If this box is checked, then 2b must be completed.

2b. Was Employee Paid for ½ Day or More on Day of Injury? ☐Yes ☐ No
(Not on the IAIABC format) Check either Yes or No.

3. ☐ Lost Earnings But No Lost Time
Check this box if the employee's earnings have been reduced because of the effects of this injury, but the employee has not lost a day's work or more **(Not on the IAIABC format).**

4. ☐ Medical/Health Care
Check this box if the employee's injury has required the services of a healthcare provider **(DN74 - CLAIM TYPE CODE=B or M)**.

5. ☐ Fatality Date of Death:
Check this box if the employee has died as a result of a job-related injury or if the employee died at the work site (DN146 – DEATH RESULT OF INJURY CODE=Y or U). If this box is checked, the date of the employee's death is mandatory **(DN57 – EMPLOYEE DATE OF DEATH).**

6a. ☐ Occupational Disease
Check this box if the employee's occupational injury, illness or death is one of the following: loss of hearing, silicosis, asbestos-related disease, or exposure to radioactive properties. **(DN290 – TYPE OF LOSS CODE=02)**. **If this box is checked, then 6b and 6c must be completed.**

6b. Date of Last Exposure: **Do not complete this box if 6a is not checked.**
If box 6a is checked, enter the last date that the employee was exposed to the cause or condition from which the occupational disease arose **(DN31 – DATE OF INURY).**

6c. Date of Diagnosis as Occupationally Related: **Do not complete this box if 6a is not checked.)** If box 6a is checked, enter the date the injury, illness, or death was first diagnosed by a physician as being occupationally related. **(Not on the IAIABC format)**

7a. ☐ Correct Prior Report
Check this box if you are correcting a prior report **(DN2 – MAINTENANCE TYPE CODE= 02 or CO) If this box is checked, then 7b and 7c must be completed.**

7b. Date of Correction: **Do not complete this box if 7a is not checked.**
If box 7a is checked, enter the date that this form was corrected
(DN3 – MAINTENANCE TYPE CODE DATE)

7c. Date correction Sent to WCB: **Do not complete this box if 7a is not checked.**
If box 7a is checked, enter the date that the corrected copy of this form was sent to the Board **(DN3 – MAINTENANCE TYPE CODE DATE)**

8. State Employer Unemployment Insurance Account Number (UIAN): **(Mandatory) (DN329 – EMPLOYER UI NUMBER)**
Enter the UIAN of the employer where the employee was employed at the time of the injury. This 10-digit number is assigned by the Maine Department of Labor to all employers who are liable for contributions for unemployment insurance. If the employer is not liable for contributions to unemployment insurance, the employer will not have a UIAN and must, therefore, call the Coverage Division of the Board (287-7092) to ask for an identification number.

9. Federal Employer Identification Number (FEIN): **(Expected) (DN16 - EMPLOYER FEIN)**
Enter the FEIN of the employer where the employee was employed at the time of the injury. This 9-digit number is assigned by the Federal Internal Revenue Service (IRS) to report all monies paid to the IRS. In some cases, this is the same as the employer's social security number.

10. Employer Name: **(Mandatory) (DN18 – EMPLOYER NAME)**
Enter the legal name of the employer.

11. Street/P.O. Box Mailing Address:
DN168 – EMPLOYER MAILING PRIMARY ADDRESS (Expected)
DN169 – EMPLOYER MAILING SECONDARY ADDRESS (Expected Conditional)
Enter the primary and secondary (if applicable) mailing addresses of the employer.

12. City: **(Expected) (DN165 – EMPLOYER MAILING CITY)**
Enter the city of the employer's mailing address.

13. State: **(Expected) (DN170 – EMPLOYER MAILING STATE CODE)**
Enter the state of the employer's mailing address.

14. Zip: **(Expected) (DN167 – EMPLOYER MAILING POSTAL CODE)**
Enter the postal code of the employer's mailing address.

15. Telephone Number: **(If Available) (DN159 – EMPLOYER CONTACT BUSINESS PHONE NUMBER)**
Enter the phone number of the employer, including area code.

16. Primary Business Performed by Employer Where Injury Occurred: **(If Available) (DN25 – INDUSTRY CODE)**

Enter the code representing the nature of the employer's business which is contained in the industrial classification manual published by the Federal Office of Management and Budget.

17. Employer Location If Different from Mailing Address:

DN019 – EMPLOYER PHYSICAL PRIMARY ADDRESS (Expected Conditional)
DN020 – EMPLOYER PHYSICAL SECONDARY ADDRESS (If Available)
DN021 – EMPLOYER PHYSICAL CITY (Expected Conditional)
DN022 – EMPLOYER PHYSICAL STATE CODE (Expected Conditional)
DN023 – EMPLOYER PHYSICAL POSTAL CODE (Expected)
DN164 – EMPLOYER PHYSICAL COUNTRY CODE (Expected Conditional)
Values: see http://www.iaiabc.org/

Enter the employer's physical location if it differs from the employer's mailing address. If the employer has multiple locations, use the address for the place of business where the injured employee was working at the time of the injury.

18. Did Injury or Exposure Occur on Employer's Premises? **(Mandatory) (DN249 – ACCIDENT PREMISES CODE)** □ Yes **(DN249=E)** □ No **(DN249=L or X)**

If No, Then Give Name and Physical Address of the Employer Where the Employee was Injured or Exposed: **(Expected Conditional)**

DN120 – ACCIDENT SITE ORGANIZATION NAME
DN119 – ACCIDENT SITE LOCATION NARRATIVE (location not post office identifiable)
DN122 – ACCIDENT SITE STREET
DN121 – ACCIDENT SITE CITY
DN123 – ACCIDENT SITE STATE CODE
DN033 – ACCIDENT SITE POSTAL CODE
DN118 – ACCIDENT SITE COUNTY/PARISH
DN280 – ACCIDENT SITE COUNTRY CODE Values: see http://www.iaiabc.org/

If the employee was not injured on the employer's premises, then enter the name and physical address of the site where the employee was injured or exposed.

□ **Insurer** □ **Third-Party Administrator (TPA)** □ **Self-Administered Employer**
Check the box that describes the legal entity adjusting the claim.

19. Insurance/TPA Company Name: **(Expected) (DN7 – INSURER NAME/DN188 – CLAIM ADMINISTRATOR NAME)**

Enter the legal name of the insurance company, self-insured or guarantee fund assuming the employer's financial responsibility for this claim, and the legal name of the entity adjusting the claim.

20. Policy Number: **(Not Applicable) (DN28 – POLICY NUMBER)**

Enter the policy number identifying the coverage policy in effect for the claim.

21. Insurer File Number: **(Mandatory) (DN15 – CLAIM ADMINISTRATOR CLAIM NUMBER)**
Enter an identifier for a specific claim within the claim administrator's processing system.

22. Street/P.O. Box Mailing Address:
DN10 – CLAIM ADMINISTRATOR PRIMARY ADDRESS (Expected)
DN11 – CLAIM ADMINISTRATOR SECONDARY ADDRESS (If Available)
Enter the primary and secondary (if applicable) addresses of the claim administrator.

23. City: **(Expected) (DN12 – CLAIM ADMINISTRATOR CITY)**
Enter the city of the claim administrator.

24. State: **(Expected) (DN13 - CLAIM ADMINISTRATOR STATE)**
Enter the state of the claim administrator.

25. Zip: **(Mandatory) (DN14 - CLAIM ADMINISTRATOR POSTAL CODE)**
Enter the postal code of the claim administrator.

26. Telephone number: **(Not on the IAIABC format)**
Enter the telephone number, including area code, of the claim administrator.

27. Last Name:
(DN43 – EMPLOYEE LAST NAME) (Mandatory)
(DN255 – EMPLOYEE LAST NAME SUFFIX) (If Available)
Enter the employee's legally recognized last name and last name suffix.

28. First Name: **(Mandatory) - (DN44 – EMPLOYEE FIRST NAME)**
Enter the employee's first name.

29. MI: **(If Available) (DN45 – EMPLOYEE MIDDLE NAME/INITIAL)**
Enter the employee's middle initial.

30. Home Phone #: **(If Available) (DN51 – EMPLOYEE PHONE NUMBER)**
Enter the employee's home telephone number, including area code.

31. Social Security Number: **(Mandatory)**
Enter the employee's ID #.
Values: DN042 – EMPLOYEE SSN (DN270=S)
DN152 – EMPLOYEE EMPLOYMENT VISA (DN270=E)
DN153 – EMPLOYEE GREEN CARD (DN270=G)
DN154 – EMPLOYEE ID ASSIGNED BY JURISDICTION (DN270=A)
DN156 – EMPLOYEE PASSPORT NUMBER (DN270=P)

32. Gender: □ Male □ Female **(Expected) (DN53 – EMPLOYEE GENDER CODE=M or F)**
Check either "M" for Male or "F" for Female to identify the employee's gender (check neither if DN53=U).

33. Street/P.O. Box Mailing Address:
DN46 – EMPLOYEE MAILING PRIMARY ADDRESS (Expected)
DN47 – EMPLOYE MAILING SECONDARY ADDRESS (If Available)
Enter the primary and secondary mailing addresses of the employee.

34. City: **(Expected) – (DN48 – EMPLOYEE MAILING CITY)**
Enter the city of the employee's mailing address.

35. State: **(Expected) – (DN49 – EMPLOYEE MAILING STATE CODE)**
Enter the state of the employee's mailing address.

36. Zip: **(Expected) – (DN50 – EMPLOYEE MAILING POSTAL CODE)**
Enter the postal code of the employee's mailing address.

37. Date of Birth: **(Expected) – (DN52 – EMPLOYEE DATE OF BIRTH)**
Enter the date employee was born.

38. Occupation/Job Title: **(Expected) (DN60 - OCCUPATION DESCRIPTION)**
Enter the employee's primary occupation at the time of injury, e.g., legal secretary, file clerk, computer programmer, truck driver, etc. Describe what the employee does as clearly as possible. Avoid using jargon.

39. Date of Hire: **(Expected) – (DN61 – EMPLOYEE DATE OF HIRE)**
Enter the date the employee began his/her employment with the employer under whose coverage the claim is being filed. If there have been multiple periods of employment with the same employer, this would be the beginning date of the current employment period.

40. Weekly Wage at Time of Injury **(If Available) (DN62 – WAGE)**
Enter the weekly wage the employee was receiving at the time of the injury.

41. Does Employee Work for Another Employer? □ Yes □ No **(Not on the IAIABC format)**
Check either Yes or No.

If Yes, Give Name and Address:
Enter the name and address of any other employer(s) with whom the employee was employed at the time of the injury.

42. Date of Injury or Illness: **(Mandatory) (DN31 – DATE OF INJURY)**
    For traumatic injury, enter the date on which the accident occurred. For occupational disease or cumulative injury, enter the date of last injurious exposure to the cause or substance creating the condition.

    Date Employer Notified: **(Expected) (DN40 – DATE EMPLOYER HAD KNOWLEDGE OF THE INJURY)**
    Enter the earlier of the date that the accident was reported to the employer or the date that the employer had actual knowledge of the accident or injury.

43. Date of Incapacity: **(Mandatory if DN74 – CLAIM TYPE CODE=I or L) (DN56 – INITIAL DATE DISABILITY BEGAN)**
    Enter the initial date disability began in the initial period of disability.

    Date Employer Notified: **(Mandatory if DN74 – CLAIM TYPE CODE=I or L) (DN281 – DATE EMPLOYER HAD KNOWLEDGE OF DATE OF DISABILITY)**
    Enter the date that the employer had notice or knowledge of the initial date disability began in the initial period of disability.

44. Time Employee Began Work: **(Not on the IAIABC format)**
    Enter the time the injured employee's workday began on the day of the injury.

45. Date Employer Notified Insurer/TPA: **(Expected) (DN41 – DATE CLAIM ADMINISTRATOR HAD KNOWLEDGE OF THE INJURY)**
    Enter the earlier of the date(s) the claim administrator or the insurer first received notice of the accident or injury from any source.

46. Time of Injury: **(Mandatory) (DN32 – TIME OF INJURY)**
    Enter the time (military format) of the accident/injury.

47. Has Employee Returned to Work? □ Yes □ No If box 2a is checked, check either Yes or No. **(Do not check this box if 2a is not checked.)** Check either Yes or No.
    If Yes, Give Date: **(If Available) (DN68 – INITIAL RETURN TO WORK DATE)**
    Where days lost is less than or equal to 7 days, enter the first date on which the employee actually returned to work.

48. Specific Injury or Illness: **(Expected) (DN35 – NATURE OF INJURY CODE)**
    Enter the title corresponding to the Nature of Injury Code.
    Values: see http://www.iaiabc.org/

49. Body Part(s) Affected: **(Expected) (DN36 – PART OF BODY INJURED CODE)**
    Enter the title corresponding to the Part of Body Injured Code.
    Values: see http://www.iaiabc.org/

50. All Equipment, Materials, or Chemicals Employee was Using When the Event Occurred: **(Expected) (DN37 – CAUSE OF INJURY CODE)**
    Enter the title corresponding to the Cause of the Injury Code.
    Values: see http://www.iaiabc.org/

51. Specify Activity the Employee was engaged in When the Event Occurred: **(Not on the IAIABC format)**
    Enter a brief description of what the employee was doing at the time of the injury. For example: welding, mowing grass, cooking, typing, moving furniture, etc.
    Was Activity Part of Normal Job Duties? □ Yes □ **(Not on the IAIABC format)**
    Check either Yes or No.

52. How Injury or Illness Occurred. Describe the Sequence of Events: **(Expected) (DN38 – ACCIDENT/INJURY DESCRIPTION NARRATIVE**)
    Enter a free form description of how the accident occurred and the resulting injuries.

53. Hospitalized Overnight as Inpatient? □ Yes □ No **(Not on the IAIABC format)**
    Check either Yes or No.

54. Was the Employee Treated in an Emergency Room? □ Yes □ No **(Not on the IAIABC format)**
Check either Yes or No.

55. Health Care Provider Name: **(Not on the IAIABC format)**
    Enter the name of the health care provider, if any, who provided initial medical treatment.

56. Mailing Address: **(Not on the IAIABC format)**
    Enter the address of the health care provided reported in Box 55, if applicable.

57. Telephone Number: **(Not on the IAIABC format)**
    Enter the telephone number, including area code, of the health care provider reported in Box 55, if applicable.

58. Preparer Name and Title: **(Not on the IAIABC format)**
    Enter the preparer's name and title.

59. Telephone Number: **(Not on the IAIABC format)**
    Enter the telephone number, including area code, of the preparer reported in Box 58.

60. Date Sent to WCB: **(Mandatory) (DN100 – DATE TRANSMISSION SENT)**
    Enter the actual date the batch of data was sent via EDI to the Board.

NOTES

WAGE STATEMENT

STATE OF MAINE
WORKERS' COMPENSATION BOARD
STATION 27, AUGUSTA, MAINE 04333-0027

1. INSURER FILE NUMBER:	6. SOCIAL SECURITY NUMBER		7. WCB FILE NUMBER:	
2. EMPLOYER NAME:	8. EMPLOYEE LAST NAME:		9. FIRST NAME:	10. M.I.:
3. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:	11. ADDRESS-NUMBER AND STREET:			
4. INSURER NAME:	12. CITY:	13. STATE:	14. ZIP:	15. HOME PHONE:
5. INSURER MAILING ADDRESS:	16. DATE OF INJURY:	17. DESCRIPTION OF INJURY:		

18. DOES EMPLOYEE WORK FOR ANOTHER EMPLOYER? IF YES, THE EMPLOYER SHALL SUBMIT A WAGE STATEMENT FROM EACH ADDITIONAL EMPLOYER.	YES ☐ NO ☐	19. DOES EMPLOYEE RECEIVE FRINGE BENEFITS THAT MAY STOP WHILE ON WORKERS; COMPENSATION?.	YES ☐ NO ☐

20.

WK	WEEK ENDING	GROSS EARNINGS	WK			WK		
1			19			37		
2			20			38		
3			21			39		
4			22			40		
5			23			41		
6			24			42		
7			25			43		
8			26			44		
9			27			45		
10			28			46		
11			29			47		
12			30			48		
13			31			49		
14			32			50		
15			33			51		
16			34			52		
17			35			**21. TOTAL EARNINGS**	**$**	
18			36			**22. GROSS AVERAGE WEEKLY WAGE**	**$**	

23. PREPARER NAME AND TITLE (TYPE OR PRINT):	24. TELEPHONE NUMBER:	25. DATE MAILED:

THE STATE OF MAINE DOES NOT DISCRIMINATE ON THE BASIS OF DISABILITY IN ADMISSION TO, ACCESS TO, OR OPERATION OF ITS PROGRAMS, SERVICES, OR ACTIVITIES. THIS FORM IS AVAILABLE IN ALTERNATIVE FORMAT. FOR FURTHER ASSISTANCE, CONTACT THE MAINE WORKERS' COMPENSATION BOARD, ADA COORDINATOR, TELEPHONE: 1-888-801-9087 OR TTY (877) 832-5525
WCB 2 (6/11)
Distribution: (1) Workers' Compensation Board, (2) Employee, (3) Insurer, (4) Employer

WAGE STATEMENT, WCB-2

Reporting Requirements

The employer or insurer (which can sometimes be one and the same) must file a Wage Statement within 30 days after the employer receives notice or has knowledge of a claim for compensation (box 28 of the Memorandum of Payment, WCB-3, or box 20 of the Notice of Controversy, WCB-9).

Distribution

A Wage Statement is a four-part form that is to be distributed as follows:

Copy 1 to the Board via e-mail, via fax, or via standard mail at:

Workers' Compensation Board
27 State House Station
Augusta, Maine 04333-0027

Copy 2 to the Employee
Copy 3 to the Insurer
Copy 4 to the Employer

Form Filing Violations

Failure to file any Board-prescribed forms within established time frames is a violation of §360(1). Violations will result in the filing of complaints with the Abuse Investigation Unit. The Abuse Investigation Unit will process the complaint in the manner set forth in Board Rule 15.9.

INSTRUCTIONS FOR COMPLETING WAGE STATEMENT, WCB-2

Identifying Information

1. Insurer File Number:
   Enter the claim administrator claim number as it was entered in box 21 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

2. Employer Name:
   Enter the employer name as it was entered in box 10 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

3. Employer Mailing Address and Phone Number:
   Enter the employer mailing address and phone number as it was entered in boxes 11-15 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

4. Insurer Name:
   Enter the legal name of the insurance company, self-insured or guarantee fund assuming the employer's financial responsibility for this claim as it was entered in box 19 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

5. Insurer Mailing Address:
   Enter the claim administrator mailing address as it was entered in boxes 22-25 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

6. Social Security Number:
   Enter the employee's ID # as it was entered in box 31 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

7. WCB File Number:
   Enter the jurisdiction claim number assigned by the Board to identify this claim.

8. Employee Last Name:
   Enter the employee's last name as it was entered in box 27 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

9. First Name:
   Enter the employee's first name as it was entered in box 28 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

10. M.I.:
    Enter the employee's middle initial as it was entered in box 29 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

11. Address – Number and Street:
    Enter the number and street of the employee's mailing address as it was entered in box 33 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

12. City:
    Enter the city of the employee's mailing address as it was entered in box 34 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

13. State:
    Enter the state of the employee's mailing address as it was entered in box 35 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

14. Zip:
    Enter the zip code of the employee's mailing address as it was entered in box 36 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

15. Home Phone Number:
    Enter the employee's home phone number as it was entered in box 30 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

16. Date of Injury:
    Enter the date of injury or illness as it was entered in box 42 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

17. Description of Injury:
    Enter a brief description of the injury or illness.

18. Does Employee Work for Another Employer?
    Check "Yes" or "No." If "Yes," the employer for whom the employee worked at the time of the injury is required to file the Wage Statement(s), WCB-2, from the employee's other employer(s). **NOTE: The employer for whom the employee worked at the time of the injury is required to file the Wage Statement(s) from the employee's other employer(s) (See §205.8).**

19. Does the employee receive fringe benefits that may stop while on Workers' Compensation?
    Check "Yes" or "No." If the employee receives any fringe or other benefit paid by the employer that does not continue during the disability, that amount must be included for purposes of determining the employee's average weekly wage. (If the employee's 80 percent net average weekly wage is less than two-thirds of the statewide average weekly wage, the employee is entitled to inclusion of fringe benefits. This inclusion, however, should not increase the employee's rate beyond two-thirds of the statewide average weekly wage.)

Wage Information

20. Weekly Wages
    If the injured employee was employed seasonally (as defined by Section 102(4)(C) of the Act) at the time of injury, enter the employer's payroll week "week ending" dates and the employee's corresponding "gross earnings" for the prior calendar year.

    For all other types of employment, enter the employer's payroll week "week ending" dates and the employee's corresponding "gross earnings" for the 52 weeks immediately preceding the injury. Week 52 is the payroll week that includes the date of injury. Week 1 is the payroll week from approximately one year prior to the injury. If the employee did not work for the employer for 52 weeks preceding the injury, refer to Section 102(4) of the Act to determine additional filing requirements.

    A legible copy of the employer's record of payments (in support of the information reported in box 20) should be attached to the Wage Statement whenever possible.

21. Total Earnings
    Enter the total of “gross earnings” reported for weeks 1 through 52.

22. Gross Average Weekly Wage
    Enter the average weekly wage. (Compute this amount in accordance with Section 102(4) of the *Maine Workers’ Compensation Act of 1992.*)

Preparer Information

23. Preparer Name and Title:
    Type or print the preparer's name and title.

24. Telephone Number:
    Enter the preparer's telephone number, including area code.

25. Date Mailed:
    Enter the date this form is sent this form is sent (mail, fax, email) to the Workers’ Compensation Board. If the form being sent is a revision of a previous form, put a line through the original "Date Sent to WCB" date and enter an amended date.

NOTES

SCHEDULE OF DEPENDENT(S) AND FILING STATUS STATEMENT

STATE OF MAINE
WORKERS' COMPENSATION BOARD
STATION 27, AUGUSTA, MAINE 04333-0027

EMPLOYER/INSURER COMPLETES BOXES 1 TO 17

1. INSURER FILE NUMBER:	6. SOCIAL SECURITY NUMBER		7. WCB FILE NUMBER:	
2. EMPLOYER NAME:	8. EMPLOYEE LAST NAME:		9. FIRST NAME:	10. M.I.:
3. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:	11. ADDRESS-NUMBER AND STREET:			
4. INSURER NAME:	12. CITY:	13. STATE:	14. ZIP:	15. HOME PHONE:
5. INSURER MAILING ADDRESS:	16. DATE OF INJURY:	17. DESCRIPTION OF INJURY:		

EMPLOYEE COMPLETES BOXES 18 TO 21

18.

FEDERAL TAX FILING STATUS

☐ **SINGLE** ☐ **MARRIED/JOINT**

☐ **SINGLE/HEAD OF HOUSEHOLD** ☐ **MARRIED/SEPARATE**

19.

DEPENDENT(S)

DEPENDENT NAMES(S) (IF NONE, SO STATE)	RELATHIONSHIP (I.E., SPOUSE, DAUGHTER, SON)	DATE OF BIRTH	SOCIAL SECURITY NUMBER (IF NONE, SO STATE)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

20. EMPLOYEE SIGNATURE:	21. DATE MAILED:

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WCB 2A (8/94)

Distribution: (1) Workers' Compensation Board, (2) Employee, (3) Insurer, (4) Employer

SCHEDULE OF DEPENDENT(S) AND FILING STATUS STATEMENT, WCB-2A

Reporting Requirements

The employer or insurer (which can sometimes be one and the same) must file a Schedule of Dependent(s) and Filing Status Statement within 30 days after the employer's notice or knowledge of a claim for compensation (box 28 of the first Memorandum of Payment, WCB-3, or box 20 of the Notice of Controversy, WCB-9).

Distribution

The Schedule of Dependent(s) and Filing Status Statement is a four-part form that is to be distributed as follows:

Copy 1 to the Board via e-mail, via fax, or via standard mail at:

Workers' Compensation Board
27 State House Station
Augusta, Maine 04333-0027

Copy 2 to the Employee
Copy 3 to the Insurer
Copy 4 to the Employer

INSTRUCTIONS FOR COMPLETING SCHEDULE OF DEPENDENT(S) AND FILING STATUS STATEMENT, WCB-2A

Employer/Insurer Completes Boxes 1 To 17

1. Insurer File Number:
   Enter the claim administrator claim number as it was entered in box 21 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

2. Employer Name:
   Enter the employer name as it was entered in box 10 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

3. Employer Mailing Address and Phone Number:
   Enter the employer mailing address and phone number as it was entered in boxes 11-15 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

4. Insurer Name:
   Enter the legal name of the insurance company, self-insured or guarantee fund assuming the employer's financial responsibility for this claim as it was entered in box 19 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

5. Insurer Mailing Address:
   Enter the claim administrator mailing address as it was entered in boxes 22-25 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

6. Social Security Number:
   Enter the employee's ID # as it was entered in box 31 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

7. WCB File Number:
   Enter the jurisdiction claim number assigned by the Board to identify this claim.

8. Employee Last Name:
   Enter the employee's last name as it was entered in box 27 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

9. First Name:
   Enter the employee's first name as it was entered in box 28 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

10. M.I.:
    Enter the employee's middle initial as it was entered in box 29 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

11. Address – Number and Street:
    Enter the number and street of the employee's mailing address as it was entered in box 33 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

12. City:
    Enter the city of the employee's mailing address as it was entered in box 34 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

13. State:
    Enter the state of the employee's mailing address as it was entered in box 35 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

14. Zip:
    Enter the zip code of the employee's mailing address as it was entered in box 36 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

15. Home Phone Number:
    Enter the employee's home telephone number as it was entered in box 30 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

16. Date of Injury:
    Enter the date of injury or illness as it was entered in box 42 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

17. Description of Injury:
    Enter a brief description of the injury or illness.

Employee Completes Boxes 18 To 21

18. Federal Tax Filing Status
    The employee checks the appropriate box based on the employee's Federal Income Tax Return. The filing status is determined according to IRS regulations for the year preceding the injury.

19. Dependent(s)
    The employee lists all members of the employee's household whom the employee is able to claim as dependents on the Federal Income Tax Return. The Board will accept this form without the social security number(s) of dependent(s).

20. Preparer Name and Title:
    The employee signs here.

21. Telephone Number:
    The employee enters a telephone number where he/she can be reached.

22. Date Mailed:
    The employee enters the date he/she completed the form.

NOTE: If the employee fails to (timely) complete boxes 18 through 21, then the employer/insurer can complete these boxes, based on any known filing status and dependent information. If the filing status and dependent information is unknown, we recommend a filing of "single with no dependents". The employer/insurer must document that the employee was contacted and failed to (timely) complete this section.

Upon receipt of the employee's version of the form, a copy should be forwarded to the Board along with any corresponding corrections (if applicable). The newly established weekly compensation rate is effective from the employee's date of injury.

NOTES

1. REVISION DATE: _____/_____/_____ MM DD YYYY	**MEMORANDUM OF PAYMENT**	2. WCB FILE NUMBER (if known):

EMPLOYEE

3. EMPLOYEE LAST NAME:	4. FIRST NAME:	5. MI.:	6. SOCIAL SECURITY NUMBER:

7. STREET/P.O. BOX MAILING ADDRESS:	8. CITY:	9. STATE:	10. ZIP:	11. HOME PHONE NUMBER: ( )

12. DATE OF INJURY: _____/_____/_____ MM DD YYYY	13. SPECIFIC INJURY OR ILLNESS:	14. BODY PARTS (S) AFFECTED:

EMPLOYER

15. INSURER FILE NUMBER:	16. EMPLOYER NAME:	17. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:

18. INSURER/TPA NAME:	19.INSURER/TPA MAILING ADDRESS:

NOTICE TO EMPLOYEE

20. YOUR EMPLOYER/INSURER IS REQUIRED TO FILE THIS WORKERS' COMPENSATION FORM UPON PAYMENT OF A LOST TIME WORK-RELATED INJURY. PAYMENT IS MADE FOR THE FOLLOWING REASON:

A. ☐ YOUR CLAIM IS ACCEPTED.
B. ☐ THIS IS A VOLUNTARY PAYMENT PENDING INVESTIGATION.
C. ☐ THIS IS A MANDATORY PAYMENT BECAUSE A NOTICE OF CONTROVERSY WAS NOT TIMELY FILED PURSUANT TO RULE 1.1.
PERIOD COVERED BY MANDATORY PAYMENT: FROM (DATE) ____/____/____ (MM DD YYYY) THROUGH (DATE) ____/____/____ (MM DD YYYY) AMOUNT PAID $ _____

21. TYPE OF PAYMENT:

A. ☐ WEEKLY COMPENSATION B. ☐ SPECIFIC LOSS _____WEEKS AMOUNT PAID $ _____

C. ☐ PERMANENT IMPAIRMENT AMOUNT PAID $ _____ D. ☐ OTHER (EXPLAIN) _____

22 A. IS THERE ANY INDICATION THAT THE INJURY IS PERMANENT? ☐ YES ☐ NO
B. IF THE ANSWER IS YES, WHAT IS THE PERMANENT IMPAIRMENT RATING? % ☐ NOT YET AVAILABLE

23. DATE OF INCAPACITY: _____/_____/_____ MM DD YYYY DATE EMPLOYER NOTIFIED: ____/____/____ MM DD YYYY	24. DATE CHECK MAILED: ____/____/____ MM DD YYYY	25. AVERAGE WEEKLY WAGE: $	26. CURRENT WEEKLY COMPENSATION RATE: ☐ TOTAL ☐ PARTIAL $

27. DOES EMPLOYEE WORK FOR ANOTHER EMPLOYER? ☐ YES ☐ NO IF YES, GIVE NAME:	28. FIRST DAY OF COMPENSABILITY AFTER WAITING PERIOD IS MET: ____/____/____ MM DD YYYY

29. IS THIS AN APPORTIONMENT CLAIM? ☐ YES ☐ NO IF YES, ANSWER THE FOLLOWING:

OTHER DATE(S) OF INJURY INVOLVED: _____

OTHER CARRIER(S) INVOLVED: _____

WHO IS THE "LEAD" CARRIER? _____

EXPLAIN THE TERMS OF THE APPORTIONMENT: _____

30. COMMENTS:

ASSISTANCE IS AVAILABLE AT THE MAINE WORKERS' COMPENSATION BOARD'S REGIONAL OFFICES

AUGUSTA	BANGOR	CARIBOU	LEWISTON	PORTLAND
24 STONE ST. AUGUSTA, ME 04330-5220 (207)287-2308 (Voice) (207)287-6119 (TTY) 1-800-400-6854 (Voice)	106 HOGAN ROAD BANGOR, ME 04401-5638 (207)941-4550 1-800-400-6856	43 HATCH DRIVE CARIBOU, ME 04736-2347 (207)498-6428 1-800-400-6855	140 CANAL ST. LEWISTON, ME 04240-7777 (207)783-5490 1-800-400-6857	62 ELM ST. PORTLAND, ME 04101-3061 (207)822-0840 1-800-400-6858

31. CLAIM HANDLER NAME (TYPE OR PRINT): E-MAIL ADDRESS:	32. TELEPHONE NUMBER: ( ) TOLL FREE NUMBER: ( )	33. DATE SENT TO WCB: _____/_____/_____ MM DD YYYY

WCB-3 (10/98) THE STATE OF MAINE DOES NOT DISCRIMINATE ON THE BASIS OF DISABILITY IN ADMISSION TO, ACCESS TO, OR OPERATION OF ITS PROGRAMS, SERVICES, OR ACTIVITIES. THIS FORM IS AVAILABLE IN ALTERNATIVE FORMAT. FOR FURTHER ASSISTANCE, CONTACT THE MAINE WORKERS' COMPENSATION BOARD, ADA COORDINATOR, TELEPHONE: 1-888-801-9087 OR TTY (877) 832-5525.

DISTRIBUTION: COPY (1) MAINE WORKERS' COMPENSATION BOARD, 27 STATE HOUSE STATION, AUGUSTA, MAINE 04333-0027, (2) EMPLOYEE, (3) INSURER, (4) EMPLOYER

MEMORANDUM OF PAYMENT, WCB-3

Reporting Requirements

The employer or insurer (which can sometimes be one and the same) must file a Memorandum of Payment (MOP) with the Board: (1) upon making the first payment of weekly compensation for incapacity due to occupational injury, disease, or death, (2) upon making payment to the Treasurer of Maine in case of the death of any employee when there is no person entitled to compensation, (3) upon making the first payment of weekly compensation for specific loss benefits, (4) upon making a payment of compensation for permanent impairment (pre 1993 claims only), (5) upon making a payment of compensation pursuant to a decision of the Board, (6) upon making a payment of compensation pursuant to Rule 1.1(2), or (7) once indemnity benefits would otherwise be payable after the seven-day wait period is met for cases involving salary continuation.

A MOP must be sent to the Board on or before the 14th day payment is due under §205(2) and must be received at the Board by the 17th day (three mail days are provided for receipt by the Board where the form is sent via standard mail). Evidence of timely mailing is a rebuttable presumption to a determination of noncompliance under §360(1).

Other Requirements

Compliance with the initial indemnity payment obligation exists when the check is mailed within the later of: 1) 14 days after the employer's notice or knowledge of incapacity or 2) the first day of compensability plus 6 days. If an employer continues to pay the employee's salary, payments are deemed timely for purposes of compliance if made consistent with the employer's usual payroll practice.

The employer or insurer (which can sometimes be one and the same) must file a Schedule of Dependent(s) and Filing Status Statement within 30 days after the employer's notice or knowledge of a claim for compensation (box 28 of the first Memorandum of Payment, WCB-3).

Distribution

A MOP is a four-part form that is to be distributed as follows:

Copy 1 to the Board via e-mail, via fax, or via standard mail at:

Workers' Compensation Board
27 State House Station
Augusta, Maine 04333-0027

Copy 2 Employee
Copy 3 Insurer
Copy 4 Employer

Closure

Closure of all MOPs other than those issued pursuant to Rule 1.1(3) is required. Closure occurs when one of the following actions is taken:

1) File a Discontinuance or Modification of Compensation, WCB-4, when:

   a. The employee has returned to work for the employer of injury and/or the employee's post-injury wages (from the employer of injury) equal or exceed his/her pre-injury AWW

   b. The employee has returned to work for the employer of injury without restrictions or limitations (due to the injury for which benefits are being paid), according to the employee's treating health care providers and there are no conflicting medical records with respect to the lack of restrictions or limitations (due to the injury for which benefits are being paid)

   c. Board decision (e.g. a mediation agreement, Consent Decree, Hearing Officer Decree, or Lump Sum Settlement)

2) File a Certificate of Discontinuance or Reduction of Compensation, WCB-8, when:

   a. Indemnity benefits are suspended in accordance with §205(9)(B)(1)

3) File a Petition when:

   a. Indemnity benefits are suspended in accordance with §205(9)(B)(2)

Form Filing Violations

Failure to file any Board-prescribed forms within established time frames is a violation under §360(1). Violations may result in the filing of complaints with the Abuse Investigation Unit. The Abuse Investigation Unit will process complaints in the manner set forth in Rule 15.9.

Other Violations

Failure to file a Notice of Controversy (denial) or pay benefits on or before the 14th day payment is due under §205(2) is a violation of Rule 1.1(1). This violation requires payment of benefits to the injured employee as set forth in Rule 1.1(2), which must be reported on a MOP, as required by Rule 1.1(3).

Failure to file a denial or pay benefits on or before 30 days after the 14th day payment is due under §205(2) requires a penalty payment to the injured employee, as set forth in §205(3).

INSTRUCTIONS FOR COMPLETING MEMORANDUM OF PAYMENT, WCB-3

1. Revision Date: ___/___/____ (MM DD YYYY)

   If you are amending any information on this form that has already been filed with the parties involved (Board, employee, insurer, employer), enter the date (month, day, year) that this amended form is sent to the parties.

2. WCB File Number:
   Enter the jurisdiction claim number assigned by the Board to identify this claim.

Employee

3. Employee Last Name:
   Enter the employee's last name as it was entered in box 27 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

4. First Name:
   Enter the employee's first name as it was entered in box 28 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

5. M.I.:
   Enter the employee's middle initial as it was entered in box 29 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

6. Social Security Number:
   Enter the employee's ID # as it was entered in box 31 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

7. Street/P.O. Box Mailing Address:
   Enter the number and street of the employee's mailing address as it was entered in box 33 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

8. City:
   Enter the city of the employee's mailing address as it was entered in box 34 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

9. State:
   Enter the state of the employee's mailing address as it was entered in box 35 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

10. Zip:
    Enter the zip code of the employee's mailing address as it was entered in box 36 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

11. Home Phone Number:
    Enter the employee's home telephone number as it was entered in box 30 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

12. Date of Injury: ___/___/____
    MM DD YYYY

    Enter the date of injury or illness as it was entered in box 42 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

13. Specific Injury or Illness:
    Enter the specific injury or illness as it was entered in box 48 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

14. Body Part(s) Affected:
    Enter body part(s) affected as it was entered in box 49 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

Employer

15. Insurer File Number:
    Enter the claim administrator claim number as it was entered in box 21 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

16. Employer Name:
    Enter the employer name as it was entered in box 10 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

17. Employer Mailing Address and Phone Number:
    Enter the employer mailing address and phone number as it was entered in boxes 11-15 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

18. Insurer/TPA Name:
    Enter the legal name of the insurance company, self-insured or guarantee fund assuming the employer's financial responsibility for this claim, and the legal name of the entity adjusting the claim as it was entered in box 19 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

19. Insurer/TPA Mailing Address:
    Enter the claim administrator mailing address as it was entered in boxes 22-25 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

Notice to Employee

20. Your Employer/Insurer is required to file this Workers' Compensation form upon payment of a lost time work-related injury. Payment is made for the following reason:

A. ☐ Your Claim is Accepted (payment with prejudice).
Check box A if the employer/insurer is accepting the claim.

B. ☐ This is a Voluntary Payment Pending Investigation (payment w/out prejudice).
Check box B if the employer/insurer plans to investigate the claim.

C. ☐ This is a Mandatory Payment Because a Notice of Controversy Was Not Timely Filed Pursuant to Rule 1.1. Period Covered by Mandatory Payment:

From (Date)___/___/____ Through (Date)___/___/____ Amount Paid $_____
MM DD YYYY MM DD YYYY

Check box C if payment is required because a Notice of Controversy was not timely filed pursuant to Rule 1.1. The employee must be paid total incapacity benefits, with credit for earnings and other statutory offsets, from the date of incapacity through the later of the filing date of a Notice of Controversy or the payment date of any accrued benefits.

21. Type of Payment:

A. ☐ Weekly Compensation (§212(1), 213(1) or former §54, 54-A, 54-B, 55, 55-A, 55-B)

B. ☐ Specific Loss _____Weeks Amount Paid $_____ (§212(3))

C. ☐ Permanent Impairment Amount Paid $_____ (Pre 1993 claims only)

D. ☐ Other (Explain) _____

Check the box that describes the reason for the payment.

If "Specific Loss" is checked, enter the number of weeks payable and the total amount to be paid through the end of the specific loss period.

If "Permanent Impairment" is checked, enter the amount paid for permanent impairment.

If "Other" is checked, enter a brief description of the type of payment, e.g. Salary Continuation, decision, occupational deafness (§612), death of any employee when there is no person entitled to compensation (§355(14)(F)), etc.

22. A. Is There Any Indication That the Injury is Permanent? ☐ Yes ☐ No

If you have received information that the injury is permanent, check "Yes", otherwise, check "No".

B. If Yes, what is the Permanent Impairment Rating? ____% ☐ Not Yet Available

If the percentage of whole body impairment is known, enter it on the line provided. Otherwise, check "Not Yet Available."

23. Date of Incapacity: ___/___/____
MM DD YYYY

Initial MOP: Enter the initial date disability began in the initial period of disability as it was entered in box 43 of the Employer's First Report of Occupational Injury or Disease, WCB-1. (Occupational disease claims: enter the date of injury reported in box 12.)

Subsequent MOP: Enter the first qualifying day of disability in the current period of disability being paid.

Specific loss claims (initial or subsequent MOP): Enter the date of the specific loss.

Date Employer Notified: ___/___/____
MM DD YYYY

Initial MOP: Enter the date that the employer had notice or knowledge of the initial date disability began in the initial period of disability.

Subsequent MOP: Enter the date that the employer had notice or knowledge of the first qualifying day of disability in the current period of disability being paid.

Specific loss claims (initial or subsequent MOP): Enter the date that the employer had notice or knowledge of the specific loss.

24. Date Check Mailed: ___/___/____
MM DD YYYY

Enter the date payment was first mailed to the employee for the current incapacity. For cases involving salary continuation, enter the date the payroll check is mailed or delivered or the salary is deposited.

25. Average Weekly Wage:

Enter the employee's average weekly wage pursuant to §102(4). If estimated, please indicate. Do not enter the escalated average weekly wage (Pre 1993 claims only).

26. Current Weekly Compensation Rate:

☐ Total ☐ Partial $

Check the appropriate box to indicate whether payment is for total or partial incapacity. Also, enter the dollar amount of the current compensation rate or applicable maximum. (Rates are based on the law in effect at the time of the injury.) Enter "Varying Rate" in place of the dollar amount for varying rates. For cases involving salary continuation, enter the compensation rate that would otherwise be paid or the applicable maximum.

27. Does Employee Work for Another Employer? ☐ Yes ☐ No

If Yes, Give Name: _____

If the employee was employed by more than one employer at the time of the injury, check "Yes", otherwise, check "No" If "Yes" is checked, enter the name of each other employer.

28. First Day of Compensability After Waiting Period is Met: ___/___/____
MM DD YYYY

Complete this box if (1) the current incapacity is subject to the seven-day waiting period provided by §204, or (2) this is the initial MOP for a firefighter claim. Otherwise, do not complete this box.

For non-firefighter claims, enter the first day of incapacity after the seven-day wait has been met. For firefighter claims, enter the date of incapacity reported in box 23.

In the case of total incapacity, the seven-day waiting period is met when the employee is incapacitated for seven calendar days (regardless of salary continuation – see below).

In the case of partial incapacity, the seven-day waiting period is met when (1) an employee loses wages because of the injury which cumulatively equal or exceed the employee's pre-injury AWW, or (2) an employee loses wages because of the injury that would otherwise require the insurer to pay one week of benefits.

For cases involving salary continuation, this calculation should be made as if the employee has lost the wage that is being continued during the time he or she is absent from work or when the employee misses time from work that equals the hours worked in a regular work week. See Appendix G for more information.

29. Is This an Apportionment Claim? ☐ Yes ☐ No If Yes, answer the following:

Other Date(s) of Injury Involved:

_____

Other Carrier(s) Involved:

_____

Who is the "Lead" Carrier?

_____

Explain the Terms of the Apportionment:

_____

If this claim has been apportioned with another work-related injury, check "Yes", otherwise, check "No". If "Yes" is checked, answer all questions asked about the apportionment.

30. Comments

Use this area to enter any additional information, explanations or clarifications. For cases involving salary continuation, enter the salary amount that is being paid and any additional partial workers' compensation benefits due under §213, as applicable.

Preparer Information

31. Claim Handler Name (Type or Print):

Enter the claim handler's name.

E-Mail Address:

Enter the claim handler's email address.

32. Telephone Number:

Enter the claim handler's telephone number, including area code.

Toll Free Number:

Enter the claim handler's toll free telephone number if one is available.

33. Date Sent to WCB: ___/___/____
MM DD YYYY

Enter the date (month, day, year) this form is sent (mail, fax, email) to the Workers' Compensation Board. If the form being sent is a revision of a previous form, maintain the original "Date Sent to WCB" date and enter the revision date in box 1.

NOTES

DISCONTINUANCE OR MODIFICATION OF COMPENSATION

STATE OF MAINE
WORKERS' COMPENSATION BOARD
STATION 27, AUGUSTA, MAINE 04333-0027

1. INSURER FILE NUMBER:	6. SOCIAL SECURITY NUMBER		7. WCB FILE NUMBER:	
2. EMPLOYER NAME:	8. EMPLOYEE LAST NAME:	9. FIRST NAME:		10. M.I.:
3. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:	11. ADDRESS-NUMBER AND STREET:			
4. INSURER NAME:	12. CITY:	13. STATE:	14. ZIP:	15. HOME PHONE:
5. INSURER MAILING ADDRESS:	16. DATE OF INJURY:	17. DESCRIPTION OF INJURY:		

DISCONTINUANCE

18 REASON FOR DISCONTINUANCE:

☐ RETURNED TO WORK FOR SAME EMPLOYER ɔ 205 (9) (A)

☐ INCREASED EARNINGS ɔ 205 (9) (A)

☐ BOARD DECISION

☐ OTHER (EXPLAIN) _____

19. PERIOD OF INCAPACITY: FROM (DATE): TO: (RETURN DATE):	20. WEEKLY COMPENSATION RATE:	21. AMOUNT PAID:	22. DATE OF FINAL PAYMENT:

MODIFICATION

23. REASON FOR MODIFICATION:

☐ RETURNED TO WORK FOR SAME ɔ 205 (9) (A)

☐ DECREASED EARNINGS

☐ AVERAGE WEEKLY WAGE ESTABLISHED

☐ INCREASED EARNINGS ɔ 205 (9) (A OTHER (EXPLAIN)

☐ COST OF LIVING ADJUSTMENTS

☐ OTHER _____

24. OLD COMPENSATION RATE:	25. NEW COMPENSATION RATE:	26. EFFECTIVE DATE OF MODIFICATION:

27. COMMENTS:

ASSISTANCE IS AVAILABLE AT THE BOARD'S REGIONAL OFFICES:

AUGUSTA
24 STONE ST
AUGUSTA, ME 04330-5220
287-2168
1-800-400-6854

BANGOR
106 HOGAN RD.
BANGOR, ME 04401-5640
941-4550
1-800-400-6856

CARIBOU
ONE VAUGHN PLACE
43 HATCH DR, STE 305
CARIBOU, ME 04736
498-6428
1-800-400-6855

LEWISTON
36 MOLLISON WAY
LEWISTON, ME 04240-5811
753-7700
1-800-400-6857

PORTLAND
62 ELM ST
PORTLAND, ME 04101-6858
822-0840
1-800-400-6858

28. PREPARER NAME AND TITLE (TYPE OR PRINT):	29. TELEPHONE NUMBER:	30. DATE MAILED:

THIS DOCUMENT MAY BE PRODUCED IN ALTERNATIVE FORMATS SUCH AS BRAILLE, LARGE PRINT AND AUDIOTAPE.
WCB 4 (8/94)
Distribution: (1) Workers' Compensation Board, (2) Employee, (3) Insurer, (4) Employer

DISCONTINUANCE OR MODIFICATION OF COMPENSATION, WCB-4

Reporting Requirements

The employer or insurer (which can sometimes be one and the same) files this form for such reasons as the discontinuance or modification of compensation pursuant to 39-A M.R.S.A. §205(9)(A) or §205(B)(2), a Board decision, a mediation agreement, cost-of-living adjustments, Social Security offsets, and unemployment compensation offsets. **NOTE: This form is not used for discontinuances or reductions under 39-A M.R.S.A. §205(9)(B)(1).**

Returned to Work for Same Employer: Reductions and discontinuances pursuant to §205(9)(A) must be based on the employee's actual earnings, however, an employer or insurer may discontinue benefits regardless of the employee's actual earnings if: (i) the employee returns to work without restrictions or limitations, due to the injury for which benefits are being paid, according to the employee's treating health care providers; and (ii) there are no conflicting medical records with respect to the lack of restrictions or limitations due to the injury for which benefits are being paid. The Discontinuance or Modification of Compensation must be filed within 14 days after the employee returns to work or receives an increase in pay.

Board Decision: When the employee's benefits are discontinued or modified in accordance with a decree, a Discontinuance or Modification of Compensation must be filed.

Mediation Agreement: When the employee's benefits are discontinued or modified in accordance with a Mediation Agreement, a Discontinuance or Modification of Compensation must be filed within 14 days from the date of the agreement.

Petition for Review: When the employee's benefits are discontinued or modified based on the amount of actual documented earnings paid to the employee after filing the petition, the employer or insurer shall file the actual documented earnings and form WCB-4 showing the adjustment that was made with the Board at the same time it files the Petition for Review. Thereafter, the employer or insurer shall, within 30 days after receipt of the actual documented earnings, file with the Board the actual documentation it has received along with form WCB-4.

Other: When the employee's benefits are discontinued, reduced or modified for any other reason (cost-of-living adjustment, Social Security offset, unemployment offset, etc.), a Discontinuance or Modification of Compensation must be filed.

Distribution

A Discontinuance or Modification of Compensation is a four-part form that is to be distributed as follows:

Copy 1 to the Board via e-mail, via fax, or via standard mail at:

Workers' Compensation Board
27 State House Station
Augusta, Maine 04333-0027

Copy 2 to the Employee
Copy 3 to the Insurer
Copy 4 to the Employer

Form Filing Violations

Failure to file any Board-prescribed forms within established time frames is a violation of §360(1). Violations will result in the filing of complaints with the Abuse Investigation Unit. The Abuse Investigation Unit will process the complaint in the manner set forth in WCB Rule 15.9.

INSTRUCTIONS FOR COMPLETING DISCONTINUANCE OR MODIFICATION OF COMPENSATION, WCB-4

Identifying Information

1. Insurer File Number:
   Enter the claim administrator claim number as it was entered in box 21 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

2. Employer Name:
   Enter the employer name as it was entered in box 10 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

3. Employer Mailing Address and Phone Number:
   Enter the employer mailing address and phone number as it was entered in boxes 11-15 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

4. Insurer Name:
   Enter the legal name of the insurance company, self-insured or guarantee fund assuming the employer's financial responsibility for this claim as it was entered in box 19 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

5. Insurer Mailing Address:
   Enter the claim administrator mailing address as it was entered in boxes 22-25 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

6. Social Security Number:
   Enter the employee's ID# as it was entered in box 31 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

7. WCB File Number:
   Enter the jurisdiction claim number assigned by the Board to identify this claim.

8. Employee Last Name:
   Enter the employee's last name as it was entered in box 27 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

9. First Name:
   Enter the employee's first name as it was entered in box 28 of the Employer's First Report of Occupational Injury of Disease, WCB-1.

10. M.I.:
    Enter the employee's middle initial as it was entered in box 29 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

11. Address – Number and Street:
    Enter the number and street of the employee's mailing address as it was entered in box 33 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

12. City:
    Enter the city of the employee's mailing address as it was entered in box 34 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

13. State:
    Enter the state of the employee's mailing address as it was entered in box 35 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

14. Zip:
    Enter the zip code of the employee's mailing address as it was entered in box 36 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

15. Home Phone Number:
    Enter the employee's home telephone number as it was entered in box 30 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

16. Date of Injury:
    Enter the date of injury or illness as it was entered in box 42 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

17. Description of Injury:
Enter a brief description of the injury or illness.

Discontinuance

18. Reason for Discontinuance:
- ☐ Returned to Work for Same Employer §205(9)(A)
- ☐ Board Decision
- ☐ Increased Earnings §205(9)(A)
- ☐ Other (Explain) _____

Check the box that describes the reason for discontinuing compensation. If "Other" is checked, provide a brief explanation for the discontinuance.

19. Period of Incapacity:
From (Date):
Enter the date this incapacity began. This date should be the same as box 23 (date of incapacity) of the Memorandum of Payment, WCB-3, for the current incapacity period.

To (Return Date): Enter the date this incapacity ended. **NOTE: Enter only one period of incapacity in box 19 per form.**

20. Weekly Compensation Rate:
Enter the weekly compensation rate used for this period of incapacity. If more than one rate was used, enter the last rate used.

21. Amount Paid:
Enter the total amount of weekly compensation paid for the period of incapacity reported in box 19. **Do not reduce this total by the amount of any recoveries. In cases involving apportionment, do not include amounts paid to the "lead" carrier.**

22. Date of Final Payment:
Enter the date the last weekly compensation payment for this period of incapacity was mailed to the employee.

Modification

23. Reason for Modification:
- ☐ Returned to Work for Same Employer §205(9)(A)
- ☐ Increased Earnings §205(9)(A)
- ☐ Decreased Earnings
- ☐ Cost of Living Adjustment (Pre 1993 claims only)
- ☐ Average Weekly Wage Established
- ☐ Other (Explain) _____

Check the box that describes the reason for modification. If "Other" is checked, provide a brief explanation for the modification.

24. Old Compensation Rate:
    Enter the compensation rate prior to the change. If varying rates were paid, enter the word "varying."

25. New Compensation Rate:
    Enter the new compensation rate. If varying rates will be paid, enter the word "varying."

26. Effective Date of Modification:
    Enter the date the rate change took effect.

27. Comments:
    Use this area to enter any additional information, explanation, or clarification.

Preparer Information

28. Preparer Name and Title:
    Type or print the preparer's name.

29. Telephone Number:
    Enter the preparer's telephone number, including area code.

30. Date Mailed:
    Enter the date this form is sent this form is sent (mail, fax, email) to the Workers' Compensation Board. If the form being sent is a revision of a previous form, put a line through the original "Date Sent to WCB" date and enter an amended date.

NOTES

CONSENT BETWEEN EMPLOYER AND EMPLOYEE

STATE OF MAINE
WORKERS' COMPENSATION BOARD
STATION 27, AUGUSTA, MAINE 04333-0027

1. INSURER FILE NUMBER:	6. SOCIAL SECURITY NUMBER		7. WCB FILE NUMBER:	
2. EMPLOYER NAME:	8. EMPLOYEE LAST NAME:		9. FIRST NAME:	10. M.I.:
3. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:	11. ADDRESS-NUMBER AND STREET:			
4. INSURER NAME:	12. CITY:	13. STATE:	14. ZIP:	15. HOME PHONE:
5. INSURER MAILING ADDRESS:	16. DATE OF INJURY:	17. DESCRIPTION OF INJURY:		

18. TERMS OF CONSENT:			
18A. DATE OF INCAPACITY:	18B. AVERAGE WEEKLY WAGE:	18C. CURRENT WEEKLY COMPENSATION RATE: ☐ TOTAL ☐ PARTIAL	18D. DOES EMPLOYEE WORK FOR ANOTHER EMPLOYER? IF YES, GIVE NAME(S): ☐ YES ☐ NO
18E. NEW COMPENSATION RATE:	18F. EFFECTIVE DATE OF REDUCTION:	18G. EFFECTIVE DATE OF DISCONTINUANCE:	18H. AMOUNT PAID:

NOTICE TO EMPLOYEE (Please read and initial)

19.
BEFORE YOU SIGN THIS FORM, YOU SHALL CALL THE WORKERS' COMPENSATION BOARD'S OFFICES TO FIND OUT WHAT RIGHTS YOU RIGHTS YOU HAVE IF YOU SIGN THIS FORM. A LIST OF THE BOARD'S REGIONAL OFFICES IS SHOWN AT THE BOTTOM OF THIS PAGE.

EMPLOYEE INITIALS: _____

NOTICE TO EMPLOYER

THIS FORM SHALL NOT BE USED FOR CASES WHEN AN ORDER, AWARD OF COMPENSATION OR A COMPENSATION SCHEME WAS ENTERED UNDER SECTION 205 (9)(B)(2).

CONSENT

20. WE AGREE TO THE TERMS LISTED IN BOX 18 ABOVE. WE UNDERSTAND THAT THIS IS NOT A FINAL SETTLEMENT. SIGNING THIS CONSENT FORM CREATES A PAYMENT WITHOUT PREJUDICE, DOES NOT CREATE A PAYMENT SCHEME, AND DOES NOT PREVENT EITHER PARTY FROM REOPENING THE CLAIM WITHIN CERTAIN
TIME LIMITS. THIS FORM MUST BE SIGNED BY THE EMPLOYEE, EMPLOYEE'S ATTORNEY OR WORKER ADVOCATE IF ANY, AND THE EMPLOYER/INSURER OR BY A DULY AUTHORIZED REPRESENTATIVE.

_____ _____
EMPLOYEE SIGNATURE DATE

_____ _____
EMPLOYEE 'S AUTHORIZED REPRESENTATIVE SIGNATURE (IF APPLICABLE) DATE

_____ _____
EMPLOYER/INSURER OR AUTHORIZED REPRESENTATIVE SIGNATURE DATE

ASSISTANCE IS AVAILABLE AT THE BOARD'S REGIONAL OFFICES:

AUGUSTA
24 STONE ST
AUGUSTA, ME 04330-5220
287-2168
1-800-400-6854

BANGOR
106 HOGAN RD.
BANGOR, ME 04401-5640
941-4550
1-800-400-6856

CARIBOU
ONE VAUGHN PLACE
43 HATCH DR, STE 305
CARIBOU, ME 04736
498-6428
1-800-400-6855

LEWISTON
36 MOLLISON WAY
LEWISTON, ME 04240-5811
753-7700
1-800-400-6857

PORTLAND
62 ELM ST
PORTLAND, ME 04101-6858
822-0840
1-800-400-6858

21. PREPARER NAME AND TITLE (TYPE OR PRINT):	22. TELEPHONE NUMBER:	23. DATE MAILED:

THE STATE OF MAINE DOES NOT DISCRIMINATE ON THE BASIS OF DISABILITY IN ADMISSION TO, ACCESS TO, OR OPERATION OF ITS PROGRAMS, SERVICES, OR ACTIVITIES. THIS FORM IS AVAILABLE IN ALTERNATIVE FORMAT. FOR FURTHER ASSISTANCE, CONTACT THE MAINE WORKERS' COMPENSATION BOARD, ADA COORDINATOR, TELEPHONE: 1-888-801-9087 OR TTY (877) 832-5525
WCB 4A (6/11)
Distribution: (1) Workers' Compensation Board, (2) Employee, (3) Insurer, (4) Employer

CONSENT BETWEEN EMPLOYER AND EMPLOYEE, WCB-4A

Reporting Requirements

Pursuant to Rule 8.18, the Consent Between Employer and Employee (WCB-4A) may be used when the parties have agreed to a voluntary payment of a retroactive closed-end period of incapacity, or a modification, reduction or discontinuance in ongoing weekly incapacity benefits.

- The Consent Between Employer and Employee (WCB-4A) can not be used to reduce or discontinue benefits on a date that is subsequent to the date the parties sign the WCB-4A.

- The WCB-4A shall be signed by the employee, the employee's attorney or worker advocate, if any, and a representative of the insurer.

- The parties may agree to the pre-injury average weekly wage or may agree to pay benefits based upon a provisional wage and reserve the issue of the pre-injury average weekly wage for later determination by the Board. In either event, the form shall also indicate whether the employee is receiving 100% of the benefits at issue for the designated period. If the employee is receiving less than 100% of the benefits at issue for the designated period, the form shall indicate the percentage of benefits that the employee is receiving.

- The employer or insurance carrier shall make compensation payments within 10 calendar days after the WCB-4A is signed by the parties.

- Signing the WCB-4A does not by itself create a compensation payment scheme.

- Upon request by any of the parties, the Consent Between Employer and Employee, WCB-4A, shall be reviewed within 14 calendar days by an agent at the Board's regional offices in order to answer any relevant questions prior to the employer and employee signing this form.

- The Consent Between Employer and Employee, WCB-4A, shall not be used when an ongoing order, award of compensation, or a compensation payment scheme is entered under § 205(9)(B)(2).

Distribution

A Consent Between Employer and Employee is a four-part form that is to be distributed as follows:

Copy 1 to the Board via e-mail, via fax, or via standard mail at:

Workers' Compensation Board
27 State House Station
Augusta, Maine 04333-0027

Copy 2 to the Employee
Copy 3 to the Insurer
Copy 4 to the Employer

Form Filing Violations

The Deputy Director of Benefits Administration will refer abuses of the Consent Between Employer and Employee, WCB-4A, to the Workers' Compensation Abuse Investigation Unit.

Other Violations

The Payments Division will review the Consent Between Employer and Employee, WCB-4A, in order to verify that the agreed upon benefits were correctly determined.

INSTRUCTIONS FOR COMPLETING CONSENT BETWEEN EMPLOYER AND EMPLOYEE, WCB-4A

Identifying Information

1. Insurer File Number:
   Enter the claim administrator claim number as it was entered in box 21 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

2. Employer Name
   Enter the employer name as it was entered in box 10 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

3. Employer Mailing Address and Phone Number
   Enter the employer mailing address and phone number as it was entered in boxes 11-15 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

4. Insurer Name
   Enter the legal name of the insurance company, self-insured or guarantee fund assuming the employer's financial responsibility for this claim as it was entered in box 19 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

5. Insurer Mailing Address
   Enter the claim administrator mailing address as it was entered in boxes 22-25 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

6. Social Security Number
   Enter the employee's ID# as it was entered in box 31 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

7. WCB File Number
   Enter the jurisdiction claim number assigned by the Board to identify this claim.

8. Employee Last Name
   Enter the employee's last name as entered in box 27 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

9. First Name
   Enter the employee's first name as it was entered in box 28 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

10. M.I.
    Enter the employee's middle initial as it was entered in box 29 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

11. Address – Number and Street
    Enter the number and street of the employee's mailing address as it was entered in box 33 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

12. City
    Enter the city of the employee's mailing address as it was entered in box 34 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

13. State
    Enter the state of the employee's mailing address as it was entered in box 35 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

14. Zip
    Enter the zip code of the employee's mailing address as it was entered in box 36 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

15. Home Phone Number
    Enter the employee's home telephone number as it was entered in box 30 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

16. Date of Injury
    Enter the date of injury or illness as it was entered in box 42 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

17. Description of Injury
    Enter a brief description of the injury or illness.

Terms of Consent

18. Terms of Consent

Enter the details/terms of the agreement between the parties. The terms shall indicate whether the employee is receiving 100% of the benefits at issue for the designated period. If the employee is receiving less than 100% of the benefits at issue for the designated period, the terms shall indicate the percentage of benefits that the employee is receiving.

18A. Date of Incapacity

Enter the date of the first day that will be compensated when the parties have agreed to a voluntary payment of a retroactive closed-end period of incapacity or the date of incapacity as entered in box 23 of the Memorandum of Payment, WCB-3 when the parties have agreed to a voluntary modification, reduction or discontinuance of compensation.

18B. Average Weekly Wage

Enter the average weekly wage as entered in box 25 of the Memorandum of Payment, WCB-3, or the average weekly wage as agreed upon by the parties, if applicable.

18C. Current Weekly Compensation Rate: ☐ Total ☐ Partial $_____

Check the appropriate box to indicate whether payment is for total or partial incapacity and enter the weekly compensation rate agreed upon by the parties when the parties have agreed to a voluntary payment of a retroactive closed-end period of incapacity or the current weekly compensation rate when the parties have agreed to a voluntary modification, reduction or discontinuance of compensation.

18D. Does Employee Work For Another Employer? ☐ Yes ☐ No

If the employee was employed by more than one employer at the time of the injury, check "Yes." Otherwise, check "No."

If Yes, Give Name(s)

If the employee was employed by more than one employer at the time of the injury, enter the name of the other employer(s).

18E. New Compensation Rate

Use this box only when the parties have agreed to a voluntary modification or reduction in compensation. Enter the new compensation rate agreed upon by the parties. If varying rates will be paid, enter the word "varying."

18F. Effective Date of Reduction

Use this box only when the parties have agreed to a voluntary modification or reduction in compensation. Enter the effective date of the modification or reduction, as agreed upon by the parties.

18G. Effective Date of Discontinuance

Use this box only when the parties have agreed to a voluntary payment of a retroactive closed-end period of incapacity or a voluntary discontinuance of compensation. Enter the effective date of the discontinuance, as agreed upon by the parties.

18H. Amount Paid

Use this box only when the parties have agreed to a voluntary payment of a retroactive closed-end period of incapacity or when the parties have agreed to a voluntary discontinuance of compensation. Enter the total amount of indemnity to be paid for the retroactive closed-end period of incapacity or for the period of incapacity being paid or discontinued by the agreement of the parties. **Do not reduce this total by the amount of any recoveries. In cases involving apportionment, do not include amounts paid to the "lead" carrier.**

Notice To Employee

19. This box should be initialed by the employee to ensure that he/she has read the notice.

Consent

20. This area shall be signed by the employee, the employee's attorney or worker advocate, if any, and a representative of the insurer before it may be accepted by the Board.

Preparer Information

21. Preparer Name and Title:

Type or print the preparer's name and title.

22. Telephone Number

Enter the preparer's telephone number, including area code.

23. Date Mailed:

Enter the date this form is sent this form is sent (mail, fax, email) to the Board.

NOTES

CERTIFICATE AUTHORIZING
RELEASE OF BENEFIT INFORMATION

STATE OF MAINE
WORKERS' COMPENSATION BOARD
STATION 27, AUGUSTA, MAINE 04333-0027

PART 1 EMPLOYER/INSURER COMPLETES BOXES 1 THROUGH 17				
1. INSURER FILE NUMBER:	6. SOCIAL SECURITY NUMBER		7. WCB FILE NUMBER:	
2. EMPLOYER NAME:	8. EMPLOYEE LAST NAME:		9. FIRST NAME:	10. M.I.:
3. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:	11. ADDRESS-NUMBER AND STREET:			
4. INSURER NAME:	12. CITY:	13. STATE:	14. ZIP:	15. HOME PHONE:
5. INSURER MAILING ADDRESS:	16. DATE OF INJURY:	17. DESCRIPTION OF INJURY:		

PART II EMPLOYEE COMPLETES THIS SECTION:

I _____, AUTHORIZE THE ABOVE-NAMED EMPLOYER/INSURER TO OBTAIN WRITTEN INFORMATION INDICATING THE NATURE AND AMOUNT OF BENEFITS I RECEIVED OR AM RECEIVING FROM THE FOLLOWING:

☐ SOCIAL SECURITY ADMINISTRATION

☐ EMPLOYEE BENEFITS PLAN(S)

_____ NAME OF EMPLOYEE BENEFIT PLAN

_____ ADDRESS - NUMBER AND STREET

_____ CITY, STATE, ZIP

I UNDERSTAND THAT THE ABOVE-NAMED EMPLOYER/INSURER IS ENTITLED TO RECEIVE THIS SOCIAL SECURITY OLD AGE INSURANCE OR EMPLOYEE BENEFIT PLAN INFORMATION PURSUANT TO 39-A M.R.S.A. SECTION 221 (5) AND THAT MY FAILURE TO COMPLETE THIS CERTIFICATE MAY RESULT IN THE DISCONTINUANCE OF MY WEEKLY WORKERS' COMPENSATION BENEFITS. THIS CERTIFICATE OF RELEASE SHALL BE VALID FOR ONE YEAR FROM THE DATE OF MY SIGNATURE.

_____ EMPLOYEE SIGNATURE _____ DATE

PART III SOCIAL SECURITY ADMINISTRATION OR EMPLOYEE BENEFIT PLAN COMPLETES THIS SECTION

TO: SOCIAL SECURITY ADMINISTRATION OR EMPLOYEE BENEFIT PLAN

THE ABOVE-NAMED EMPLOYEE AUTHORIZED THE RELEASE OF BENEFIT INFORMATION PURSUANT TO 39-A M.R.S.A. SECTION 221 (5). PLEASE PROVIDE THE FOLLOWING INFORMATION TO THE ABOVE-NAMED EMPLOYER/INSUER:

1. EFFECTIVE DATE OF ELIGIBILITY: _____
2. CURRENT GROSS MONTHLY AMOUNT: _____
3. PERCENTAGE OF EMPLOYEE BENEFIT PLAN PAID BY EMPLOYER (IF APPLICABLE): _____
4. ARE BENEFITS FROM THIS EMPLOYEE BENEFIT PLAN SUBJECT TO REDUCTION BASED ON RECEIPT OF WORKERS' COMPENSATION BENEFITS? IF YES, EXPLAIN BELOW UNDER COMMENTS.
5. COMMENTS: _____

6. PREPARER NAME AND TITLE (TYPE OR PRINT):	7. TELEPHONE NUMBER:	8. DATE MAILED:

THE STATE OF MAINE DOES NOT DISCRIMINATE ON THE BASIS OF DISABILITY IN ADMISSION TO, ACCESS TO, OR OPERATION OF ITS PROGRAMS, SERVICES, OR ACTIVITIES. THIS FORM IS AVAILABLE IN ALTERNATIVE FORMAT. FOR FURTHER ASSISTANCE, CONTACT THE MAINE WORKERS' COMPENSATION BOARD, ADA COORDINATOR, TELEPHONE: 1-888-801-9087 OR TTY (877) 832-5525
WCB 6 (3/97)
Distribution: (1) Employee, (2) Insurer, (3) Employer.

CERTIFICATE AUTHORIZING RELEASE OF BENEFIT INFORMATION, WCB-6

Reporting Requirements

The employer or insurer (which can sometimes be one and the same) may use the Certificate Authorizing Release of Benefit Information to request information about payments made to an injured employee for one of the following:

- Old-age insurance under the United States Social Security Act, 42 United States Code, §§301 to 1397f.
- An employer-funded self-insurance plan.
- An employer-funded wage continuation plan.
- An employer-funded disability insurance policy.
- An employer established or maintained pension plan or program.
- An employer established or maintained retirement plan or program.

The employer or insurer must complete Part I and have the injured employee complete Part II (release of information) before submitting the form to the Social Security Administration or other party who provides one of the above-listed employee benefit plans for completion of Part III.

Distribution

A Certificate Authorizing Release of Benefit Information is a four-part form that is to be distributed as follows:

Copy 1	to the Employee
Copy 2	to the Insurer
Copy 3	to the Employer

The Board does not receive a copy of this report.

INSTRUCTIONS FOR COMPLETING CERTIFICATE AUTHORIZING RELEASE OF BENEFIT INFORMATION, WCB-6

Part I Employer/Insurer Completes Boxes 1 Through 17

1. Insurer File Number:
   Enter the claim administrator claim number as it was entered in box 21 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

2. Employer Name:
   Enter the employer name as it was entered in box 10 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

3. Employer Mailing Address and Phone Number:
   Enter the employer mailing address and phone number as it was entered in boxes 11-15 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

4. Insurer Name:
   Enter the legal name of the insurance company, self-insured or guarantee fund assuming the employer's financial responsibility for this claim as it was entered in box 19 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

5. Insurer Mailing Address:
   Enter the claim administrator mailing address as it was entered in boxes 22-25 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

6. Social Security Number:
   Enter the employee's ID # as it was entered in box 31 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

7. WCB File Number:
   Enter the jurisdiction claim number assigned by the Board to identify this claim.

8. Employee Last Name:
   Enter the employee's last name as it was entered in box 27 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

9. First Name:
   Enter the employee's first name as it was entered in box 28 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

10. M.I.:
    Enter the employee's middle initial as it was entered in box 29 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

11. Address – Number and Street:
    Enter the number and street of the employee's mailing address as it was entered in box 33 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

12. City:
    Enter the city of the employee's mailing address as it was entered in box 34 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

13. State:
    Enter the state of the employee's mailing address as it was entered in box 35 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

14. Zip:
Enter the zip code of the employee's mailing address as it was entered in box 36 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

15. Home Phone Number:
Enter the employee's home telephone number as it was entered in box 30 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

16. Date of Injury:
Enter the date of injury or illness as it was entered in box 42 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

17. Description of Injury:
Enter a brief description of the injury or illness.

Part II Employee Completes This Section

I, _____, authorize the above-named employer/insurer to obtain written information indicating the nature and amount of benefits I received or am receiving from the following:

Enter your name on the line provided.

☐ Social Security Administration

If you receive, or have received old-age Social Security benefits, check this box.

☐ Employee Benefits Plan(s)

If you receive, or have received, benefits from another plan (self-insurance, wage continuation, disability, pension or retirement) that was established, provided or maintained by your employer (see Part I, box 14 of this form), check this box.

_____
Name of Employee Benefit Plan

_____
Address – Number and Street

_____
City, State and Zip

If you checked "Employee Benefits Plan(s)," enter the name of your benefit plan on the first line.
Enter the mailing address (street address or P.O. Box) for the benefit plan on the second line.
Enter the city, state and zip code of the mailing address for the benefit plan on the third line.

_____ _____
Employee Signature Date

Sign your name on the first line and enter the date that you signed this form on the second line.

Part III Social Security Administration or Employee Benefit Plan Completes This Section

1. Effective Date of Eligibility:
   Enter the date that the employee listed in Part I first became eligible for payments through the benefit plan listed in Part II.

2. Current Gross Monthly Amount:
   Enter the gross amount of the monthly benefit that the employee is currently being paid. If benefits are not paid monthly, enter the amount of the benefit currently being paid and the frequency of that payment (weekly, biweekly, etc.).

3. Percentage of Employee Benefit Plan Paid By Employer (If Applicable):
   Enter the percentage of the premium paid for this benefit plan that was paid by the employer listed in Part I.

4. Are Benefits from This Employee Benefit Plan Subject to Reduction Based on Receipt of Workers' Compensation Benefits? If Yes, Explain Below Under Comments.
   If this benefit plan provides for an offset of benefits payable when the employee also receives workers' compensation benefits, enter "yes." Otherwise, enter "no." If an offset is allowed, explain how the offset is calculated and applied in the "Comments" area provided.

5. Comments:
   Use this space to provide any comments.

6. Preparer Name and Title:
   The person who completes Part III of this form must sign this line. Also enter the title of the person whose signature appears in this box.

7. Telephone Number
   Enter the telephone number, including area code, of the person listed in box 6 (Part III).

8. Date Mailed:
   Enter the date that this form is sent back to the requesting party.

NOTES

CERTIFICATE OF
DISCONTINUANCE OR REDUCTION OF COMPENSATION

STATE OF MAINE
WORKERS' COMPENSATION BOARD
STATION 27, AUGUSTA, MAINE 04333-0027

1. INSURER FILE NUMBER:	6. SOCIAL SECURITY NUMBER		7. WCB FILE NUMBER:	
2. EMPLOYER NAME:	8. EMPLOYEE LAST NAME:		9. FIRST NAME:	10. M.I.:
3. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:	11. ADDRESS-NUMBER AND STREET:			
4. INSURER NAME:	12. CITY:	13. STATE:	14. ZIP:	15. HOME PHONE:
5. INSURER MAILING ADDRESS:	16. DATE OF INJURY:	17. DESCRIPTION OF INJURY:		

NOTICE TO EMPLOYEE

YOUR WEEKLY COMPENSATION BENEFITS WILL BE DISCONTINUED OR REDUCED 21 DAYS FROM THE DATE THIS CERTIFICATE WAS MAILED BASED ON THE ATTACHED INFORMATION. IF YOU DISAGREE WITH THIS ACTION, YOU ARE ENTITLED TO FILE A PETITION FOR REVIEW AND TO REQUEST THE PROVISIONAL REINSTATEMENT OF YOUR BENEFITS. YOUR PETITION AND REQUEST SHOULD BE MAILED TO THE ABOVE WORKERS' COMPENSATION BOARD ADDRESS.

18 REASON FOR DISCONTINUANCE:

DISCONTINUANCE

19. PERIOD OF INCAPACITY: FROM (DATE): TO (EFFECTIVE DATE OF DISCONTINUANCE):	20. WEEKLY COMPENSATION RATE:	21. COMPENSATION PAYMENT TO DATE OF CERTIFICATE:	22. COMPENSATION TO BE PAID FOR 21 DAY PERIOD:

REDUCTION

23. OLD COMPENSATION RATE:	24. NEW COMPENSATION RATE:	25. EFFECTIVE DATE OF REDUCTION:

26. COMMENTS:

ASSISTANCE IS AVAILABLE AT THE BOARD'S REGIONAL OFFICES:

AUGUSTA
24 STONE ST
AUGUSTA, ME 04330-5220
287-2168
1-800-400-6854

BANGOR
106 HOGAN RD.
BANGOR, ME 04401-5640
941-4550
1-800-400-6856

CARIBOU
ONE VAUGHN PLACE
43 HATCH DR, STE 305
CARIBOU, ME 04736
498-6428
1-800-400-6855

LEWISTON
36 MOLLISON WAY
LEWISTON, ME 04240-5811
753-7700
1-800-400-6857

PORTLAND
62 ELM ST
PORTLAND, ME 04101-6858
822-0840
1-800-400-6858

27. PREPARER NAME AND TITLE (TYPE OR PRINT):	28. TELEPHONE NUMBER:	29. DATE MAILED:

THE STATE OF MAINE DOES NOT DISCRIMINATE ON THE BASIS OF DISABILITY IN ADMISSION TO, ACCESS TO, OR OPERATION OF ITS PROGRAMS, SERVICES, OR ACTIVITIES. THIS FORM IS AVAILABLE IN ALTERNATIVE FORMAT. FOR FURTHER ASSISTANCE, CONTACT THE MAINE WORKERS' COMPENSATION BOARD, ADA COORDINATOR, TELEPHONE: 1-888-801-9087 OR TTY (877) 832-5525

WCB -8 (8/94) DISTRIBUTION: COPY (1) WORKERS' COMPENSATION BOARD, (2) EMPLOYEE, (3) INSURER, (4) EMPLOYER

(21-DAY) CERTIFICATE OF DISCONTINUANCE OR REDUCTION OF COMPENSATION, WCB-8

Reporting Requirements

The employer or insurer (which can sometimes be one and the same) must file a 21-Day Certificate of Discontinuance or Reduction of Compensation when compensation is discontinued or reduced pursuant to 39-A M.R.S.A. §205(9)(B)(1).

Reductions and/or discontinuances based on earnings when an employee returns to work with a different employer: When the employee's benefits are discontinued or modified based on the amount of actual documented earnings, the employer or insurer must include, with the 21-Day Certificate of Discontinuance or Reduction of Compensation, form 231-A (Employee's Return to Work Report). Within 14 calendar days after the expiration of the 21-day period, or within 14 days after receipt of documentation from the employee if the documentation is received after the expiration of the 21-day period, the employer/insurer shall file with the Board the documentation it has received along with an amended form WCB-8 which shall also include any necessary adjustments based on the documentation received by the employer/insurer.

A 21-day Certificate of Discontinuance or Reduction of Compensation must be sent **by certified mail** to the Board and to the employee (box 29).

Distribution

A Certificate of Discontinuance or Reduction of Compensation is a four-part form that is to be distributed as follows:

Copy 1 to the Board **via certified mail** at:

Workers' Compensation Board
27 State House Station
Augusta, Maine 04333-0027

Copy 2 to the Employee **via certified mail** no less than 21 days prior to the effective date (box 19 or box 25) of the form.

Copy 3 to the Insurer
Copy 4 to the Employer

INSTRUCTIONS FOR COMPLETING
CERTIFICATE OF DISCONTINUANCE OR REDUCTION OF COMPENSATION, WCB-8

Identifying Information

1. Insurer File Number:
   Enter the claim administrator claim number as it was entered in box 21 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

2. Employer Name:
   Enter the employer name as it was entered in box 10 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

3. Employer Mailing Address and Phone Number:
   Enter the employer mailing address and phone number as it was entered in boxes 11-15 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

4. Insurer Name:
   Enter the legal name of the insurance company, self-insured or guarantee fund assuming the employer's financial responsibility for this claim as it was entered in box 19 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

5. Insurer Mailing Address:
   Enter the claim administrator mailing address as it was entered in boxes 22-25 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

6. Social Security Number:
   Enter the employee's ID # as it was entered in box 31 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

7. WCB File Number:
   Enter the jurisdiction claim number assigned by the Board to identify this claim.

8. Employee Last Name:
   Enter the employee's last name as it was entered in box 27 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

9. First Name:
   Enter the employee's first name as it was entered in box 28 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

10. M.I.:
    Enter the employee's middle initial as it was entered in box 29 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

11. Address – Number and Street:
    Enter the number and street of the employee's mailing address as it was entered in box 33 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

12. City:
    Enter the city of the employee's mailing address as it was entered in box 34 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

13. State:
    Enter the state of the employee's mailing address as it was entered in box 35 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

14. Zip:
    Enter the zip code of the employee's mailing address as it was entered in box 36 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

15. Home Phone Number:
    Enter the employee's home phone number as it was entered in box 30 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

16. Date of Injury:
    Enter the date of injury or illness as it was entered in box 42 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

17. Description of Injury:
    Enter a brief description of the injury or illness.

18. Reason for Discontinuance or Reduction of Benefits:
    Enter the reason for discontinuing or reducing compensation, and attach any information that the employer, insurer, or self-insured used to support this action.

Discontinuance

19. Period of Incapacity:
    From (Date):
    Enter the date this period of incapacity began. This date should be the same as box 23 of the Memorandum of Payment, WCB-3, for the current incapacity period. **NOTE: Enter only one period of incapacity in box 19 per form.**

    To (Effective Date of Discontinuance):
    Enter the date payment for the incapacity will end (no earlier than 21 days from the date the Certificate of Discontinuance or Reduction of Compensation is mailed, box 29). Do not count the day the Certificate of Discontinuance or Reduction of Compensation is mailed to calculate the 21-day period.

EXAMPLE: May 5 (date certificate is mailed, box 29)
+21 (days)
= May 26 (effective date of discontinuance)

20. Weekly Compensation Rate:
Enter the weekly compensation rate (in dollars and cents, unless varying rates are paid) used for this period of incapacity. If more than one rate was used, enter the last rate used.

21. Compensation Payment to Date of Certificate:
Enter the total amount of weekly compensation (in dollars and cents) due to date (date the Certificate of Discontinuance or Reduction of Compensation is mailed) for the current incapacity period. **Do not reduce this total by the amount of any recoveries.**

22. Compensation to be Paid for 21-Day Period:
Enter the total anticipated amount of weekly compensation (in dollars and cents) to be paid for the 21-day notice period.

Reduction

23. Old Compensation Rate:
Enter the compensation rate prior to change. If varying rates were paid, enter the word "varying."

24. New Compensation Rate:
Enter the new compensation rate. If varying rates will be paid, enter the word "varying."

25. Effective Date of Reduction:
Enter the date payment for the incapacity will be reduced (no earlier than 21 days from the date the Certificate of Discontinuance or Reduction of Compensation is mailed, box 29). Do not count the day the Certificate of Discontinuance or Reduction of Compensation is mailed to calculate the 21-day period.

EXAMPLE: May 5 (date certificate is mailed, box 29)
+21 (days)
= May 26 (effective date of reduction)

26. Comments
Use this space for any comments.

Preparer Information

27. Preparer Name and Title
Type or print the preparer's name.

28. Telephone Number
Enter the preparer's telephone number, including area code.

29. Date Mailed

Enter the date the Certificate of Discontinuance or Reduction of Compensation was mailed certified to the injured employee and the Board. This date should be 21 days prior to the effective date shown in box 19 (discontinuance) or box 25 (reduction) and match the postmark on the Certified Sender's Receipt.

NOTES

NOTICE OF CONTROVERSY

THIS IS A DENIAL OF YOUR BENEFITS

(Note: the DN Numbers represent a crosswalk to the IAIABC Claims Release 3 EDI data elements.)

1. WCB FILE # (if known): DN5

EMPLOYEE

2. EMPLOYEE LAST NAME:	3. FIRST NAME:	4. MI:	5. EMPLOYEE ID:
DN43 & DN255	DN44	DN45	TYPE: DN270 # DN(42/152/153/154/156)

6. STREET/P.O. BOX MAILING ADDRESS:	7. CITY:	8. STATE:	9. ZIP:	10. HOME PHONE #:
NA – DN46 (will print all NA boxes with data from FROI)	NA – DN48	NA – DN49	NA – DN50	NA - 51

11. DATE OF INJURY:	12. SPECIFIC INJURY OR ILLNESS:	13. BODY PART(S) AFFECTED:
DN31 ____/____/____	NA-DN35	NA – DN36

EMPLOYER

14. INSURER/CLAIM ADMIN FILE #:	15. EMPLOYER NAME:	16. EMPLOYER MAILING ADDRESS AND PHONE #:
DN15	NA – DN18	NA – DN168, 165, 170, 167, and 159

17. INSURER/CLAIM ADMIN NAME AND ADDRESS:	18. INSURER/CLAIM ADMIN FEIN:
DN188, NA – DN10, 12, 13, and 14	DN187

19. **NOTICE TO EMPLOYEE**

YOUR EMPLOYER/INSURER IS DENYING YOUR WORKERS' COMPENSATION CLAIM OR PART OF IT. THE REASON FOR THE DENIAL IS CHECKED BELOW. IF YOU DISAGREE WITH THIS DENIAL, CONTACT A CLAIMS RESOLUTION SPECIALIST AT THE NEAREST REGIONAL OFFICE LISTED BELOW.

19a. **FULL DENIAL REASON**

DN198

19b. **PARTIAL DENIAL REASON**

DN294

20a. DATE OF INITIAL INCAPACITY ___/DN56/___

CURRENT DATE OF INCAPACITY ___/DN144/___

20b. DATE EMPLOYER NOTIFIED ____/DN281_/____

FULL DENIAL EFFECTIVE DATE ___/DN199_/____

*NOTE: Reasons identified in boxes 19a or 19b will not preclude a party from raising additional issues at a later date.

21. **COMMENTS:**

DN197

22. **IF THIS DENIAL NOTICE IS NOT TIMELY PURSUANT TO RULE 1.1,** the employee must be paid total benefits, with credit for earnings and other statutory offsets, from the date of incapacity in accordance with 39-A M.R.S.A. § 205(2) and in compliance with 39-A M.R.S.A. § 204. The requirement for payment of benefits under this subsection automatically ceases upon the filing of a Notice of Controversy and the payment of any accrued benefits. Payment under Rule 1.1 requires filing of a Memorandum of Payment.

ASSISTANCE IS AVAILABLE AT THE MAINE WORKERS' COMPENSATION BOARD'S REGIONAL OFFICES

AUGUSTA	BANGOR	CARIBOU	LEWISTON	PORTLAND
24 STONE ST. SUITE 2	106 HOGAN ROAD	43 HATCH DRIVE SUITE 110	36 MOLLISON WAY	62 ELM ST.
AUGUSTA, ME	BANGOR, ME	CARIBOU, ME	LEWISTON, ME	PORTLAND, ME
04330-5220	04401-5638	04736-2347	04240-5811	04101-3061
(207)287-2308 (Voice)	(207)941-4550	(207)498-6428	(207)753-7700	(207)822-0840
1-800-400-6854 (Voice)	1-800-400-6856	1-800-400-6855	1-800-400-6857	1-800-400-6858
TTY 1-877-832-5525				

23. NAME (TYPE OR PRINT):	24. TELEPHONE #:	25. DATE SENT TO WCB:
DN140	( ) DN137	____/DN100_/____
E-MAIL ADDRESS: DN138		26. DATE RCVD AT THE WCB (WCB use only): ____/____/____

WCB-9 (1/12/06) The State of Maine does not discriminate on the basis of disability in admission to, access to, or operation of its programs, services, or activities. This form is available in alternative format. For further assistance, contact the Maine Workers' Compensation Board, ADA Coordinator, telephone: 1-888-801-9087 or TTY (877) 832-5525.
DISTRIBUTION: COPY (1) EMPLOYEE, (2) EMPLOYER

NOTICE OF CONTROVERSY (DENIAL), WCB-9

General Reporting Requirements
The employer or insurer (which can sometimes be one and the same) must file* a Notice of Controversy (NOC) with the Board to report the denial of a claim for incapacity (disability), death and/or medical benefit(s).

Denial of Incapacity (disability) Benefits: Where the claim for incapacity (disability) benefits is in dispute, a NOC must be filed* on or before the 14th day payment is due under §205(2).

Denial of Death Benefits: Where the claim for death benefits is in dispute, a NOC must be filed* on or before the 14th day payment is due under §205(2).

Denial of Medical Benefits: Where the employee's claim is only for medical benefits, a NOC shall be filed* on or before the 30th day after notice or knowledge of the claim for medical benefits. See Rule 8.2 for exceptions and further instructions.

Other Reporting Requirements
The employer or insurer (which can sometimes be one and the same) must file a Schedule of Dependent(s) and Filing Status Statement within 30 days after the employer's notice or knowledge of a claim for compensation (box 20 of NOC, WCB-9).

EDI Reporting Requirements
Unless a waiver has been granted, effective July 1, 2006, all denials and all MTC "CO" corrections to denials (that are the result of a "TE" transaction error) shall be filed* using the International Association of Industrial Accident Boards and Commissions (IAIABC) Claims Release 3 format. See Rule 3.4. Following is a general overview. More detailed information can be found at: http://www.state.me.us/wcb/departments/technology/electronic.htm.

Each transaction requires a Maintenance Type Code (MTC). The MTC is a code that identifies the type of transaction:

MTC Code	Definition
CO	Correction: Correct transaction reported on the AKC as "TE" (see below). This transaction must contain the Maintenance Type Correction Code (MTCC) and Maintenance Type Correction Code Date (MTCC Date) fields. These fields communicate which report is being corrected. The jurisdiction claim number/WCBN is mandatory for this transaction.
04	Full Denial: A FROI 04 transaction indicates an original/new FROI and the filing of a Full Denial simultaneously. This MTC can only be used if the FROI has never been filed with the Board.

* accepted EDI transaction, with or without errors ("TE" or "TA" only)

04	Full Denial: A SROI 04 transaction indicates a Full Denial on a FROI that has been previously filed with the Board. The jurisdiction claim number/WCBN is mandatory for this transaction.
PD	Partial Denial: A SROI PD transaction indicates a Partial Denial. The jurisdiction claim number/WCBN is mandatory for this transaction.

If the claim is being denied in part, the FROI must be filed* prior to the submission of the Partial Denial. If the claim is being denied in full, the employer or insurer may file* a FROI 04 (the original FROI and Full Denial in one transaction).

Each transaction is acknowledged with an Application Acknowledgement Code (DN0111) used to identify the accepted/rejected status of the transaction being acknowledged:

DN0111	**Definition**
HD	Batch Rejected: Batch rejected in its entirety.
TA	Transaction Accepted: The transaction was accepted without errors.
TE	Transaction Accepted with Error: An error was found on an expected data element. A CO (Correction) must be submitted to resolve the error(s).
TN	Transaction Rejected by Service Provider: The transaction fails mandatory requirements.
TR	Transaction Rejected: The transaction was not accepted. An error was found on a mandatory or mandatory conditional data element. A review of the error(s) must take place to determine if the transaction should be resubmitted with the same MTC – correcting the error. If an error of duplicate transaction, invalid event sequence, etc. then resubmission may not be required.

It is the claim administrator's responsibility to maintain the Acknowledgment (AKC) for every batch of EDI transactions sent to the Board. A denial is not considered filed with the Board until it receives a "TA" or "TE" code on the AKC.

Corrections

Changes to NOCs filed prior to July 1, 2006 using a paper WCB-9 (10/98) must be made by sending an amended paper WCB-9 (10/98) to the Board via e-mail, via fax (207-287-5895), or via standard mail at the following address:

Workers' Compensation Board
27 State House Station
Augusta, ME 04333-0027

PLEASE ENSURE THAT THE FORM IS CLEARLY MARKED AS AN AMENDMENT AND CIRCLE OR HIGHLIGHT THE INFORMATION TO BE CHANGED.

* accepted EDI transaction, with or without errors ("TE" or "TA" only)

A MTC "CO" EDI transaction must be sent to the Board to correct any errors that were received on a "TE" acknowledgement report.

Changes/updates to denials that have been filed electronically (and are not the result of a "TE" transaction error) must be made by sending a paper WCB-9 (1/12/06) to the Board via e-mail, via fax (207-287-5895), or via standard mail at the following address:

Workers' Compensation Board
27 State House Station
Augusta, ME 04333-0027

PLEASE ENSURE THAT THE FORM IS CLEARLY MARKED AS AN AMENDMENT AND CIRCLE OR HIGHLIGHT THE INFORMATION TO BE CHANGED.

Distribution

WCB-9 (1/12/06) shall be mailed to the employee, the employer and, if required by Rule 5.7(2) or Rule 8.2, the health care provider, within 24 hours after the denial is transmitted to the Board.

Closure

Closure of the denial is required. Closure occurs when one of the following actions is taken:

1) The employer or carrier withdraws the denial. This requires the filing of a Memorandum of Payment, WCB-3, when indemnity payments are made.
2) Denied benefit(s) are not pursued.
3) The parties reach agreement outside of the litigation process. This requires the filing of a Memorandum of Payment, WCB-3, or a Consent Between Employer and Employee form, WCB-4A, when the agreement includes indemnity payments.
4) The parties reach agreement at Mediation. This requires the filing of a Memorandum of Payment, WCB-3, when the agreement includes indemnity payments.
5) A petition is filed by the denied party after unsuccessful Mediation.

Form Filing Violations

Failure to file any Board-prescribed forms within established time frames is a violation under §360(1). Violations may result in the filing of complaints with the Abuse Investigation Unit. The Abuse Investigation Unit will process complaints in the manner set forth in Rule 15.9.

Other Violations

Failure to deny or pay benefits on or before the 14th day payment is due under §205(2) is a violation of Rule 1.1(1). This violation requires payment of benefits to the injured employee as set forth in Rule 1.1(2), which must be reported on a Memorandum of Payment, WCB-3, as required by Rule 1.1(3). Failure to deny or pay benefits on or before 30 days after the 14th day payment is due under §205(2) requires a penalty payment to the injured employee, as set forth in §205(3). Failure to deny or pay medical benefits within 30 days after receipt of notice of nonpayment by certified mail requires a penalty payment to the provider of the medical or health care services or the employee who paid for the medical or health care services, as set forth in §205(4).

INSTRUCTIONS FOR COMPLETING NOTICE OF CONTROVERSY, WCB-9

For instructional purposes, this Forms Manual indicates the WCB-9 Box # and description as listed on the paper form, the IAIABC Data Element Number (DN) and the data requirements of each field to assist claim administrators with electronic filing and paper distribution of denials. Specific technical questions can be answered by reviewing the Element Requirement Tables that are available at: http://www.state.me.us/wcb/departments/technology/edirule.htm.

Certain fields are mandatory at the time of the EDI transaction. If any "mandatory" fields are missing, incomplete or incorrect, the EDI transaction will completely reject, resulting in a "TR" on the AKC. A "TR" on the AKC means that the EDI transaction was completely rejected. The fatal error(s) that caused the rejection must be corrected and a new EDI transaction must be sent as if it had never sent it in before. Other fields are given an expected rating which indicates that the data in those fields is expected by the Board. If any "expected" fields are missing, incomplete or incorrect, the denial will be accepted (filed) with errors. The error(s) must be corrected by submitting a MTC "CO" using the jurisdiction claim number/WCBN provided in the acknowledgement report.

1. WCB File # (if known): **(Assigned for FROI 04; Mandatory for SROI CO, SROI 04 and SROI PD) (DN5 – JURISDICTION CLAIM NUMBER)**
   Enter the file number assigned by the Board to identify this claim**.**

2. Employee Last Name:
   (DN43 – EMPLOYEE LAST NAME) (Mandatory)
   (DN255- EMPLOYEE LAST NAME SUFFIX) (If Available)
   Enter the employee's legally recognized last name and last name suffix.

3. First Name: **(Mandatory) (DN44 – EMPLOYEE FIRST NAME)**
   Enter the employee's first name.

4. MI: **(If Available) (DN45 – EMPLOYEE MIDDLE NAME/INITIAL)**
   Enter the employee's middle initial.

5. Employee ID: **(Mandatory)**
   Enter the employee's ID type (**DN270 – EMPLOYEE ID TYPE QUALIFIER)**
   Values: A= Employee ID Assigned by Jurisdiction (DN154)
   E= Employee Employment Visa (DN152)
   G=Employee Green Card (DN153)
   P=Employee Passport Number (DN156)
   S=Employee Social Security Number (DN42)

   Enter the employee's ID #: **(Expected)**
   DN042 – EMPLOYEE SSN
   DN152 – EMPLOYEE EMPLOYMENT VISA
   DN153 – EMPLOYEE GREEN CARD
   DN154 – EMPLOYEE ID ASSIGNED BY JURISDICTION
   DN156 – EMPLOYEE PASSPORT NUMBER

6. Street/P.O. Box Mailing Address: **(Expected on FROI 04) (DN46 – EMPLOYEE MAILING PRIMARY ADDRESS)**
   Enter the employee's mailing address.

7. City: **(Expected on FROI 04) (DN48 – EMPLOYEE MAILING CITY)**
   Enter the city of the employee's mailing address.

8. State: **(Expected on FROI 04) (DN49 – EMPLOYEE MAILING STATE CODE)**
   Enter the state of the employee's mailing address.

9. Zip: **(Expected on FROI 04) (DN50 – EMPLOYEE MAILING POSTAL CODE)**
   Enter the postal code of the employee's mailing address.

10. Home Phone #: **(If Available) (DN51 – EMPLOYEE PHONE NUMBER)**
    Enter the employee's home telephone number, including area code.

11. Date of Injury: **(Mandatory) (DN31 – DATE OF INJURY)**
    Enter the date of the employee's injury.

12. Specific Injury or Illness: **(Expected on FROI 04) (DN35 – NATURE OF INJURY CODE)**
    Enter the title corresponding to the Nature of Injury Code.
    Values: see http://www.iaiabc.org/

13. Body Part(s) Affected: **(Expected on FROI 04) (DN36 – PART OF BODY INJURED CODE)**
    Enter the title corresponding to the Part of Body Injured Code.
    Values: see http://www.iaiabc.org/

14. Insurer/Claim Admin File #: **(Mandatory) (DN15 – CLAIM ADMINISTRATOR CLAIM NUMBER)**
    Enter an identifier for a specific claim within the claim administrator's processing system.

15. Employer Name: **(Mandatory on FROI 04) (DN18 – EMPLOYER NAME)**
    Enter the legal name of the employer.

16. Employer Mailing Address and Phone #:
    DN168 – EMPLOYER MAILING PRIMARY ADDRESS (Expected on FROI 04)
    DN165 – EMPLOYER MAILING CITY (Expected on FROI 04)
    DN170 – EMPLOYER MAILING STATE CODE (Expected on FROI 04)
    DN167 – EMPLOYER MAILING POSTAL CODE (Expected on FROI 04)
    DN159 – EMPLOYER CONTACT BUSINESS PHONE NUMBER (If Available)
    Enter the primary mailing address, city, state, postal code, and phone number of the employer.

17. Insurer/Claim Admin Name: **(Expected) (DN188 – CLAIM ADMINISTRATOR NAME)**
Enter the legal name of the entity adjusting the claim.

Insurer/Claim Admin Address:
DN10 – CLAIM ADMINISTRATOR PRIMARY ADDRESS (Expected on FROI 04)
DN12 – CLAIM ADMINISTRATOR CITY (Expected on FROI 04)
DN13 – CLAIM ADMINISTRATOR STATE CODE (Expected on FROI 04)
DN14 – CLAIM ADMINISTRATOR POSTAL CODE (Mandatory)
Enter the address, city, state, and postal code of the claim adjusting office handling the claim.

18. Insurer/Claim Admin FEIN: **(Mandatory) (DN187 – CLAIM ADMINISTRATOR FEIN)**
Enter the Federal Employer Identification Number of the entity licensed or allowed by a jurisdiction to adjust a claim.

19a. Full Denial Reason **(Mandatory on FROI 04 and SROI 04) (DN198 – FULL DENIAL REASON CODE)**
Enter the code(s) used to identify the reasons for denying a claim in its entirety.
Values (Enter no more than five):
1=No Compensable Accident (A,B,C,D,E,F,G or H)
2=No Causal Relationship (A,B,C,D,E or F)
3=No Coverage (A,B,C,D,E,F,G or H)
4=Substance Use/Abuse (A)
5=Other (not elsewhere classified) (A or C)

Full Denial Effective Date **(Mandatory on FROI 04 and SROI 04) (DN199 – FULL DENIAL EFFECTIVE DATE)**
Enter the date from which the claim administrator is denying all benefits for the claim.

19b. Partial Denial Reason **(Mandatory on SROI PD) (DN294 – PARTIAL DENIAL CODE)**
Enter a code identifying which portion of the claim is being denied.
Values:
A=Denying Indemnity in Whole, not Medical
B=Denying Indemnity in Part, not Medical
C=Denying Medical in Whole, Not Indemnity
D=Denying Medical in Part, Not Indemnity
E=Denying Indemnity in Whole, Medical in Part
F=Denying Medical in Whole, Indemnity in Part
G=Denying Both Indemnity & Medical in Part

20a. Date of Initial Incapacity **(Expected for Lost Time Claims) (DN56 – INITIAL DATE DISABILITY BEGAN)**
Enter the first day qualifying as a day of disability in the first period of disability. If the period of disability has been intermittent or sporadic, please include comments in Box 21 (DN197).

Current Date of Incapacity **(If Applicable) (DN144 – CURRENT DATE DISABILITY BEGAN)**

Enter the first qualifying day of disability in the current period of disability being denied. If this date is the same as DN56, leave blank.

If the period of disability has been intermittent or sporadic, please include comments in Box 21 (DN197).

20b. Date Employer Notified **(Mandatory for Lost Time Claims) (DN281 – DATE EMPLOYER HAD KNOWLEDGE OF DATE OF DISABILITY)**

Enter the date that the employer was notified or had knowledge of the employee's work-related disability/incapacity (DN56 or DN144 as applicable to this transaction).

21. Comments: **(If Applicable) (DN197 – DENIAL REASON NARRATIVE)**

Use this area to enter any additional information, explanations or clarifications.

PLEASE INCLUDE THE NAME AND CONTACT INFORMATION OF THE HEALH CARE PROVIDER IF THE DENIAL IS CONTROVERTING WHETHER A HEALTH CARE PROVIDER'S BILL IS REASONABLE AND PROPER UNDER 39-A M.R.S.A. SEC. 206.

22. **IF THIS DENIAL NOTICE IS NOT TIMELY PURSUANT TO RULE 1.1,** the employee must be paid total benefits, with credit for earnings and other statutory offsets, from the date of incapacity in accordance with 39-A M.R.S.A. Sec. 205(2) and in compliance with 39-A M.R.S.A. Sec. 204. The requirement for payment of benefits under this subsection automatically ceases upon the filing of a denial and the payment of any accrued benefits.

23. Name: **(Expected on SROI 04 and SROI PD) (DN140 – CLAIM ADMINISTRATOR CLAIM REPRESENTATIVE NAME)**

Enter the name of the individual working for the claim administrator that is responsible for handling the claim.

E-Mail Address: **(If Available) (DN138 – CLAIM ADMINISTRATOR CLAIM REPRESENTATIVE E-MAIL ADDRESS)**

Enter the internet E-mail address of the individual responsible for handling the claim.

24. Telephone #: **(If Available) (DN137 – CLAIM ADMINISTRATOR CLAIM REPRESENTATIVE BUSINESS PHONE NUMBER)**

Enter the telephone number of the individual responsible for handling the claim.

25. Date Sent to WCB: **(Mandatory) (DN100 – DATE TRANSMISSION SENT)**

Enter the actual date the batch of data was sent via EDI to the Board.

NOTES

LUMP SUM SETTLEMENT

STATE OF MAINE
WORKERS' COMPENSATION BOARD
STATION 27, AUGUSTA, MAINE 04333-0027

1. INSURER FILE NUMBER:	6. SOCIAL SECURITY NUMBER		7. WCB FILE NUMBER:	
2. EMPLOYER NAME:	8. EMPLOYEE LAST NAME:		9. FIRST NAME:	10. M.I.:
3. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:	11. ADDRESS NUMBER AND STREET:			
4. INSURER NAME:	12. CITY:	13. STATE:	14. ZIP:	15. HOME PHONE:
5. INSURER MAILING ADDRESS:	16. DATE OF INJURY:	17. DESCRIPTION OF INJURY:		

18. TYPE OF SETTLEMENT:

☐ STRUCTURED SETTLEMENT (ATTACH DOCUMENTATION)

☐ LUMP SUM SETTLEMENT TOTAL VALUE OF SETTLEMENT $ _____

19. PERMANENT IMPAIRMENT RATING _____ % AMOUNT PAID $ _____

20. COMMENTS:

21. PREPARER NAME AND TITLE (TYPE OR PRINT):	22. TELEPHONE NUMBER:	23. DATE:

RELEASE

24. EMPLOYEE/DEPENDENT :

I AM THE PERSON ENTITLED TO WORKERS' COMPENSATION BENEFITS ON ACCOUNT OF THIS INJURY OR DEATH. I HAVE READ THIS WORKSHEET AND ALL ATTACHMENTS. WHEN I RECEIVE THE AMOUNT SHOWN ABOVE AND THIS SETTLEMENT IS APPROVED BY THE HEARING OFFICER, I RELEASE THE EMPLOYER AND INSURER NAMED ABOVE FROM ALL FURTHER LIABILITY FOR THIS INJURY. I CONSENT TO THE SETTLEMENT.

_____ _____ _____
EMPLOYEE/DEPENDENT SIGNATURE ATTORNEY SIGNATURE DATE

EMPLOYER/INSURER:

THE EMPLOYER CONSENTS TO THE SETTLEMENT: ☐ YES ☐ NO _____ SIGNATURE _____ DATE

THE INSURER CONSENTS TO THE SETTLEMENT: ☐ YES ☐ NO _____ SIGNATURE _____ DATE

DECISION

25. THE REQUESTED SETTLEMENT ***(IS/IS NOT)*** APPROVED. THE EMPLOYER/INSURER IS ORDERED TO PAY THE EMPLOYEE/DEPENDENT THE SUM OF $ __ _____ IN A LUMP SUM SETTLEMENT ACCORDING TO THE WORKERS' COMPENSATION ACT. THE EMPLOYER/INSURER IS ORDERED TO PAY ALL OUTSTANDING COMPENSATION OBLIGATIONS INCURRED PRIOR TO THIS SETTLEMENT BY THE EMPLOYE E/DEPENDENT. THE EMPLOYER/INSURER IS ORDERED TO PAY THE ATTORNEY OF THE EMPLOYEE/DEPENDENT A FEE OF $ _____ ALL PENDING PETITIONS BASED ON THIS CLAIM ARE HEREBY DISMISSED.

(CIRCLE ONE)

_____ _____
HEARING OFFICER SIGNATURE DATE

WCB 10 (3/98) THE STATE OF MAINE DOES NOT DISCRIMINATE ON THE BASIS OF DISABILITY IN ADMISSION TO, ACCESS TO, OR OPERATION OF ITS PROGRAMS, SERVICES, OR ACTIVITIES. THIS FORM IS AVAILABLE IN ALTERNATIVE FORMAT. FOR FURTHER ASSISTANCE, CONTACT THE MAINE WORKERS' COMPENSATION BOARD, ADA COORDINATOR, TELEPHONE: 1888-801-9087 OR TTY (877) 8325525 Distribution: (1) Workers' Compensation Board, (2) Employee, (3) Insurer, (4) Employer

LUMP SUM SETTLEMENT, WCB-10

The employer, insurer, third-party administrator, employee, and/or attorney files the Lump Sum Settlement form to request approval of a lump sum settlement.

A Lump Sum Settlement is a four-part form that is to be distributed as follows:

Copy 1 to the Board via e-mail, via fax, or via standard mail at:

Workers' Compensation Board
27 State House Station
Augusta, Maine 04333-0027

Copy 2 to the Employee
Copy 3 to the Insurer
Copy 4 to the Employer

INSTRUCTIONS FOR COMPLETING LUMP SUM SETTLEMENT, WCB-10

Identifying Information

1. Insurer File Number:
   Enter the claim administrator claim number as it was entered in box 21 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

2. Employer Name:
   Enter the employer name as it was entered in box 10 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

3. Employer Mailing Address and Phone Number:
   Enter the employer mailing address and phone number as it was entered in boxes 11-15 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

4. Insurer Name:
   Enter the legal name of the insurance company, self-insured or guarantee fund assuming the employer's financial responsibility for this claim as it was entered in box 19 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

5. Insurer Mailing Address:
   Enter the claim administrator mailing address as it was entered in boxes 22-25 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

6. Social Security Number:
   Enter the employee's ID# as it was entered in box 31 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

7. WCB File Number:
   Enter the jurisdiction claim number assigned by the Board to identify this claim.

8. Employee Last Name:
   Enter the employee's last name as it was entered in box 27 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

9. First Name:
   Enter the employee's first name as it was entered in box 28 of the Employer's First Report of Occupational Injury of Disease, WCB-1.

10. M.I.:
    Enter the employee's middle initial as it was entered in box 29 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

11. Address – Number and Street:
    Enter the number and street of the employee's mailing address as it was entered in box 33 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

12. City:
    Enter the city of the employee's mailing address as it was entered in box 34 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

13. State:
    Enter the state of the employee's mailing address as it was entered in box 35 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

14. Zip:
    Enter the zip code of the employee's mailing address as it was entered in box 36 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

15. Home Phone Number:
    Enter the employee's home telephone number as it was entered in box 30 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

16. Date of Injury:
    Enter the date of injury or illness as it was entered in box 42 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

17. Description of Injury:
    Enter a brief description of the injury or illness.

Type of Settlement

18. Check the box that describes the type of settlement. If the settlement is structured, attach the appropriate documentation. If the settlement is a straight lump sum, enter the total value.

Permanent Impairment Rating/Amount Paid

19. Enter the percentage of whole body permanent impairment rating and the amount paid.

Comments

20. Use this space for any comments.

Preparer Information

21. Preparer Name and Title
    Type or print the preparer's name and title.

22. Telephone Number
    Enter the preparer's telephone number, including area code.

23. Date
    Enter the date this form is completed.

Release

24. This box is for the employee/dependent, attorney(s), insurer, third-party administrator, and employer to sign and date, whether or not they agree with the requested lump sum settlement.

Decision

25. This box is to be used only by the Hearing Officer.

NOTES

STATEMENT OF COMPENSATION PAID

STATE OF MAINE
WORKERS' COMPENSATION BOARD
STATION 27, AUGUSTA, MAINE 04333-0027

1. INSURER FILE NUMBER:	6. SOCIAL SECURITY NUMBER		7. WCB FILE NUMBER:	
2. EMPLOYER NAME:	8. EMPLOYEE LAST NAME:		9. FIRST NAME:	10. M.I.:
3. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:	11. ADDRESS-NUMBER AND STREET:			
4. INSURER NAME:	12. CITY:	13. STATE:	14. ZIP:	15. HOME PHONE:
5. INSURER MAILING ADDRESS:	16. DATE OF INJURY:	17. DESCRIPTION OF INJURY:		

NOTICE TO EMPLOYEE

THIS REPORT IS A PAYMENT SUMMARY OF YOUR CLAIM. PLEASE KEEP FOR YOUR RECORDS.

18. ☐ INTERIM REPORT (ONGOING PAYMENTS) ☐ FINAL REPORT

19. A. IS THERE ANY INDICATION THAT THE INJURY IS PERMANENT? ☐ YES ☐ NO
B. IF THE ANSWER IS YES, WHAT IS THE PERMANENT IMPAIRMENT RATING? _____ % ☐ NOT YET AVAILABLE.

PAYMENT SUMMARY

20. LIST CUMULATIVE TOTALS:

MEDICAL	$	DEATH BENEFIT/FUNERAL EXPENSE	$
WEEKLY COMPENSATION	$	LEGAL EXPENSE (EMPLOYEE RELATED)	$
PERMANENT IMPAIRMENT	$	LEGAL EXPENSE (EMPLOYER RELATED)	$
REHABILITATION EXPENSE	$	OTHER PAYMENTS	$
LUMP SUM SETTLEMENT	$		
		TOTAL PAID	$

ASSISTANCE IS AVAILABLE AT THE BOARD'S REGIONAL OFFICES:

AUGUSTA
24 STONE ST
AUGUSTA, ME 04330-5220
287-2168
1-800-400-6854

BANGOR
106 HOGAN RD.
BANGOR, ME 04401-5640
941-4550
1-800-400-6856

CARIBOU
ONE VAUGHN PLACE
43 HATCH DR, STE 305
CARIBOU, ME 04736
498-6428
1-800-400-6855

LEWISTON
36 MOLLISON WAY
LEWISTON, ME 04240-5811
753-7700
1-800-400-6857

PORTLAND
62 ELM ST
PORTLAND, ME 04101-6858
822-0840
1-800-400-6858

21. PREPARER NAME AND TITLE (TYPE OR PRINT):	22. TELEPHONE NUMBER:	23. DATE:

THE STATE OF MAINE DOES NOT DISCRIMINATE ON THE BASIS OF DISABILITY IN ADMISSION TO, ACCESS TO, OR OPERATION OF ITS PROGRAMS, SERVICES, OR ACTIVITIES. THIS FORM IS AVAILABLE IN ALTERNATIVE FORMAT. FOR FURTHER ASSISTANCE, CONTACT THE MAINE WORKERS' COMPENSATION BOARD, ADA COORDINATOR, TELEPHONE: 1-888-801-9087 OR TTY (877) 832-5525WCB 11 (3/98)
Distribution: (1) Workers' Compensation Board, (2) Employee, (3) Insurer, (4) Employer

STATEMENT OF COMPENSATION PAID, WCB-11

Reporting Requirements

The initial Statement of Compensation Paid, Interim Report (WCB-11) shall be filed with the Board within 195 days of the date of an injury where indemnity payments have been made, and as a Final Report when no further payments are anticipated. Subsequent Statements of Compensation Paid (WCB-11) shall thereafter be filed with the Board within fifteen (15) days of each anniversary date of an injury when payments of any type have been made since the previous Statement of Compensation Paid (WCB-11). The Statement of Compensation Paid (WCB-11) is required when only medical payments are made subsequent to the filing of a Final Report. There is no requirement to file the Statement of Compensation Paid on claims when payments are made for medical only services and no indemnity was ever paid on the claim (Rule 8.1).

Distribution

A Statement of Compensation Paid is a four-part form that is to be distributed as follows:

Copy 1 Workers' Compensation Board via e-mail, via fax, or via standard mail at:

Workers' Compensation Board
27 State House Station
Augusta, Maine 04333-0027

Copy 2 Employee
Copy 3 Insurer
Copy 4 Employer

Form Filing Violations

Failure to file any Board-prescribed forms within established time frames is a violation under §360(1). Violations may result in the filing of complaints with the Abuse Investigation Unit. The Abuse Investigation Unit will process the complaint in the manner set forth in WCB Rule 15.9.

INSTRUCTIONS FOR COMPLETING
STATEMENT OF COMPENSATION PAID, WCB-11

Identifying Information

1. Insurer File Number:
   Enter the claim administrator claim number as it was entered in box 21 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

2. Employer Name:
   Enter the employer name as it was entered in box 10 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

3. Employer Mailing Address and Phone Number:
   Enter the employer mailing address and phone number as it was entered in boxes 11-15 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

4. Insurer Name:
   Enter the insurer name as it was entered in box 19 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

5. Insurer Mailing Address:
   Enter the insurer mailing address as it was entered in boxes 22-25 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

6. Social Security Number:
   Enter the employee's ID # as it was entered in box 31 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

7. WCB File Number:
   Enter the jurisdiction claim number assigned by the Board to identify this claim.

8. Employee Last Name:
   Enter the employee's last name as it was entered in box 27 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

9. First Name:
   Enter the employee's first name as it was entered in box 28 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

10. M.I.:
    Enter the employee's middle initial as it was entered in box 29 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

11. Address – Number and Street:
    Enter the number and street of the employee's mailing address as it was entered in box 33 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

12. City:
    Enter the city of the employee's mailing address as it was entered in box 34 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

13. State:
    Enter the state of the employee's mailing address as it was entered in box 35 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

14. Zip:
    Enter the zip code of the employee's mailing address as it was entered in box 36 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

15. Home Phone:
    Enter the employee's home telephone number as it was entered in box 30 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

16. Date of Injury:
    Enter the date of injury or illness as it was entered in box 42 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

17. Description of Injury:
    Enter a brief description of the injury or illness.

Payment Summary

18. ☐ INTERIM REPORT (ONGOING PAYMENTS) ☐ FINAL REPORT
    Check the box that describes the type of report being filed.

19. A. Is There Any Indication That the Injury is Permanent? ☐ Yes ☐ No

    If you have received information that the injury is permanent, check "Yes", otherwise, check "No".

    B. If Yes, what is the Permanent Impairment Rating? ____% ☐ Not Yet Available

    If the percentage of whole body impairment is known, enter it on the line provided. Otherwise, check "Not Yet Available."

20. List Cumulative Totals:

Do not include any penalty amounts (<u>regardless of fault</u>).

In cases involving apportionment, do not include amounts paid to the "lead" carrier.

Do not reduce these totals by the amount of any recoveries, including deductibles.

<u>Medical</u> – enter the sum of medical, surgical and hospital services, nursing, medicines, and mechanical, surgical aids paid for this claim.

<u>Weekly Compensation</u> – enter the sum of indemnity benefits paid for this claim (dependent benefits, specific loss benefits and mandatory payments are considered weekly compensation benefits). **When filing this form as a "Final Report", This amount must match the sum of the "amount paid" on all WCB-4, WCB-4A and mandatory Memorandum of Payment forms and/or the sum of the "Compensation Payment to Date of Certificate" and "Compensation to be Paid for 21-Day Period" on all WCB-8 forms.**

<u>Permanent Impairment</u> – enter the sum of permanent impairment benefits paid for this claim (pre 1993 claims only).

<u>Rehabilitation Expense</u> – enter the sum of vocational rehabilitation expenses paid for this claim.

<u>Lump Sum Settlement</u> – enter the amount of any lump sum settlement approved by a Board Hearing Officer for this claim (include the amount of any Medicare Set-Aside).

<u>Death Benefit/Funeral Expense</u> – enter the sum of funeral expenses paid for this claim (cannot exceed $7,000.00).

<u>Legal Expense (Employee Related)</u> – enter the sum of the claimant's legal expenses paid for this claim.

<u>Legal Expense (Employer Related)</u> – enter the sum of the employer's legal expenses paid for this claim.

<u>Other</u> – enter the sum of all other payments not otherwise reported for this claim.

<u>Total Paid</u> - enter the total amount paid for all categories.

EXAMPLE: The following has been paid on a claim:

Payments to physicians	$ 500.00
Payments to hospitals	$1,000.00
Temporary Total Disability	$2,000.00

A $1,000.00 deductible has been recovered from the employer.

The amounts shown in box 20 should be as follows:

Medical	$1,500.00
Weekly Compensation	$2,000.00

Preparer Information

21. Preparer Name and Title (Type or Print):
    Enter the preparer's name and title.

22. Telephone Number
    Enter the preparer's telephone number, including area code.

23. Date Mailed
    Enter the date (month, day, year) this form is sent (mail, fax, email) to the Board. When revising a previously filed form, put a line through the original "Date Sent to WCB" date and note the revision date.

NOTES

LIMITED CERTIFICATE AUTHORIZING WRITTEN RELEASE OF MEDICAL / HEALTH CARE INFORMATION

STATE OF MAINE
WORKERS'COMPENSATION BOARD
27 STATE HOUSE STATION
AUGUSTA, MAINE 04333-0027

EMPLOYEE:_____ ADDRESS:_____

DATE OF INJURY:_____ SOCIAL SECURITY NUMBER:_____

BRIEF DESCRIPTION OF BODY PART(S) INJURED:_____

_____

_____

EMPLOYER:_____ ADDRESS:_____

INSURER:_____ ADDRESS:_____

ATTORNEY:_____ ADDRESS:_____

I hereby authorize the above employer, insurer, or their attorney to obtain from any hospital, physician, osteopath, chiropractor, or other health care provider, after payment to the provider of a reasonable fee, any written information only which is or has been prepared in connection with my examination or treatment regardless of date which relates to my _____(i.e. body part and/or condition) only. This certificate of authorization remains valid and must be honored for as long as I continue to make any claim for compensation, any compensation payment scheme remains in effect, or I receive compensation. This certificate of authorization does NOT permit the release of any information regarding psychological, substance abuse, sexually transmitted disease treatment, testing, or counseling and does NOT authorize oral communication with or by any health care provider.

_____ _____
EMPLOYEE SIGNATURE DATE

NOTICE TO THE EMPLOYEE

YOU HAVE 20 DAYS FROM RECEIPT OF THIS CERTIFICATE TO SIGN AND RETURN IT TO THE EMPLOYER OR INSURER. FAILURE TO SIGN AND RETURN THIS CERTIFICATE MAY RESULT IN A SUSPENSION OF ACTIVITY ON YOUR CLAIM FOR COMPENSATION, OR IF YOU ARE CURRENTLY RECEIVING COMPENSATION, YOUR PAYMENTS OF COMPENSATION MAY BE SUSPENDED UNTIL YOU SIGN AND RETURN THIS CERTIFICATE.

THIS IS THE AUTHORIZED FORM FOR THE RELEASE OF MEDICAL AND RELATED INFORMATION UNDER THE MAINE WORKERS' COMPENSATION ACT AND IS INTENDED TO SUPPLEMENT THE RIGHTS TO SECURE MEDICAL INFORMATION SET FORTH BY TITLE 39-A OF THE MAINE REVISED STATUTES ANNOTATED AND CHAPTER 12, SECTION 18 OF THE BOARD'S RULES AND REGULATIONS.

WCB-220(4/96) DISTRIBUTION: COPY (1) INSURER, (2) EMPLOYER, (3) EMPLOYEE

LIMITED CERTIFICATE AUTHORIZING WRITTEN RELEASE OF MEDICAL/HEALTH CARE INFORMATION, WCB-220

Filing Requirements

The employer or insurer (which can sometimes be one and the same) may use the Limited Certificate Authorizing Written Release of Medical/Health Care Information to request medical/healthcare records of an injured employee. This release applies only to medical/healthcare records that are related to the specific body part(s) or condition(s) listed on this form.

The employer/insurer must complete all informational areas of this form (except for "Employee Signature" and "Date") before asking the employee to sign, date and return the form to them. This release in not valid without the employee's signature (or the signature of a person who has power of attorney for the injured employee).

Distribution

The Limited Certificate Authorizing Written Release of Medical/Health Care Information is a three-part form that is to be distributed as follows:

Copy 1	to the Employee
Copy 2	to the Insurer
Copy 3	to the Employer

The Board does not receive a copy of this report.

INSTRUCTIONS FOR COMPLETING LIMITED CERTIFICATE AUTHORIZING WRITTEN RELEASE OF MEDICAL/HEALTH CARE INFORMATION, WCB-220

Employee: _____

Enter the injured employee's name (first name, middle initial, last name).

Address: _____

Enter the employee's mailing address (street or P.O. Box, city, state and zip code).

Date of Injury: _____

Enter the date of the employee's injury. This date should be the same as box 42 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

Social Security Number: _____

Enter the employee's social security number.

Brief Description of Body Part(s) Injured: _____

Enter a list of the body parts affected by the injury or illness. When specifying a part of the body, be sure to indicate whether it is "left" or "right." When the injury involves fingers or toes, use the numbers one through five to describe the body part. (One is the thumb or big toe; five is the little finger or little toe.)

Employer: _____

Enter the employer name as it was entered in box 10 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

Address: _____

Enter the address where the employer receives mail. Also enter the employer's phone number, including area code.

Insurer: _____

Enter the name of the employer's workers' compensation insurance company. If the employer is self-insured or group self-insured, indicate this and provide the name of the third-party administrator if there is one.

Address: _____

Enter the insurer, self-insured, or third-party administrator's mailing address.

Attorney (Legal Representative): _____

If the employee is represented by a legal representative, enter the name of that legal representative.

Address: _____

Enter the legal representative's mailing address.

I hereby authorize the above employer, insurer, or their attorney to obtain from any hospital, physician, osteopath, chiropractor, or other health care provider, after payment to the provider of a reasonable fee, any written information only which is or has been prepared in connection with my examination or treatment regardless of date which relates to my _____ (i.e. body part and/or condition) only. This certificate of authorization remains valid and must be honored for as long as I continue to make any claim for compensation, any compensation payment scheme remains in effect, or I receive compensation. This certificate of authorization does NOT permit the release of any information regarding psychological, substance abuse, sexually transmitted disease treatment, testing, or counseling and does NOT authorize oral communication with or by any health care provider.

_____ _____

Employee Signature Date

The body part and/or condition blank must be completed. The injured employee, or a person who holds power of attorney for the employee, **must** sign the first line and enter the date of their signature on the second line.

NOTES

EMPLOYMENT STATUS REPORT

STATE OF MAINE
WORKERS' COMPENSATION BOARD
STATION 27, AUGUSTA, MAINE 04333-0027

PART 1 (COMPLETED BY EMPLOYER/INSURER

1. INSURER FILE NUMBER:	6. SOCIAL SECURITY NUMBER		7. WCB FILE NUMBER:	
2. EMPLOYER NAME:	8. EMPLOYEE LAST NAME:		9. FIRST NAME:	10. M.I.:
3. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:	11. ADDRESS-NUMBER AND STREET:			
4. INSURER NAME:	12. CITY:	13. STATE:	14. ZIP:	15. HOME PHONE:
5. INSURER MAILING ADDRESS:	16. DATE OF INJURY:	17. DESCRIPTION OF INJURY:		

18.

NOTICE TO EMPLOYEE

THIS REPORT IS DUE 90 DAYS AFTER THE DATE OF INJURY, AND EVERY 90 DAYS THEREAFTER, PURSUANT TO 39-A M.R.S.A. § 308 (2). ANY EMPLOYER REQUESTING A QUARTERLY REPORT MUST PROVIDE THE EMPLOYEE WITH THIS REPORT AT LEAST 15 DAYS PRIOR TO THE DATE ON WHICH IT IS DUE. **FAILURE TO COMPLETE AND RETURN THIS REPORT MAY RESULT IN THE DISCONTINUANCE OF YOUR WORKERS' COMPENSATION BENEFITS.**

THIS REPORT IS DUE: _____, 19 _____

THIS REPORT COVERS THE PERIOD FROM _____, 19_____ TO _____, 19_____

THIS COMPLETED REPORT SHOULD BE RETURNED TO:

_____

_____

_____

PART 2 (COMPLETED BY THE EMPLOYEE)

19.

A. DID YOU WORK OR PERFORM ANY SERVICES FOR PAY OR OTHER BENEFIT DURING THE PERIOD STATED IN THE ABOVE SECTION? ☐ YES ☐ NO

B. IF YES, COMPLETE THE FOLLOWING AND **ATTACH VERIFICATION OF INCOME** (USE REVERSE SIDE IF NECESSARY):

EMPLOYER NAME: _____ TELEPHONE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

C. WHAT TYPE(S) OF WORK DID YOU PERFORM IN THIS EMPLOYMENT?

D DATES EMPLOYED: FROM: _____, 19 _____ TO _____, 19_____

E. ARE YOU STILL EMPLOYED? ☐ YES ☐ NO

20. I HEREBY CERTIFY THAT THE INFORMATION CONTAINED IN THIS REPORT IS TRUTHFUL AND ACCURATE.

_____ _____
EMPLOYEE SIGNATURE DATE

THE STATE OF MAINE DOES NOT DISCRIMINATE ON THE BASIS OF DISABILITY IN ADMISSION TO, ACCESS TO, OR OPERATION OF ITS PROGRAMS, SERVICES, OR ACTIVITIES. THIS FORM IS AVAILABLE IN ALTERNATIVE FORMAT. FOR FURTHER ASSISTANCE, CONTACT THE MAINE WORKERS' COMPENSATION BOARD, ADA COORDINATOR, TELEPHONE: 1-888-801-9087 OR TTY (877) 832-5525

WCB 230 (8/94)

Distribution: (1) Employee, (2) Insurer, (3) Employer

EMPLOYMENT STATUS REPORT, WCB-230

Reporting Requirements

Pursuant to 39-A M.R.S.A.§308(2), at the previous employer's request, any person receiving compensation under this Act who has not returned to that person's previous employment must submit quarterly employment status reports to that employer. The report is due 90 days after the date of injury, or after the filing of the report and every 90 days thereafter. Any employer requesting a quarterly report must provide the employee with the prescribed form at least 15 days prior to the date on which it is due.

Distribution

Pursuant to Rule 1.8, the Employment Status Report is a three-part form that is to be distributed as follows:

Copy 1	to the Employee
Copy 2	to the Insurer
Copy 3	to the Employer

The Board does not receive a copy of this report.

INSTRUCTIONS FOR COMPLETING EMPLOYMENT STATUS REPORT, WCB-230

Part I Completed By Employer/Insurer

1. Insurer File Number:
   Enter the claim administrator claim number as it was entered in box 21 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

2. Employer Name:
   Enter the employer name as it was entered in box 10 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

3. Employer Mailing Address and Phone Number:
   Enter the employer mailing address and phone number as it was entered in boxes 11-15 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

4. Insurer Name:
   Enter the legal name of the insurance company, self-insured or guarantee fund assuming the employer's financial responsibility for this claim as it was entered in box 19 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

5. Insurer Mailing Address:
   Enter the claim administrator mailing address as it was entered in boxes 22-25 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

6. Social Security Number:
   Enter the employee's ID# as it was entered in box 31 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

7. WCB File Number:
   Enter the jurisdiction claim number assigned by the Board to identify this claim.

8. Employee Last Name:
   Enter the employee's last name as it was entered in box 27 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

9. First Name:
   Enter the employee's first name as it was entered in box 28 of the Employer's First Report of Occupational Injury of Disease, WCB-1.

10. M.I.:
    Enter the employee's middle initial as it was entered in box 29 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

11. Address – Number and Street:
    Enter the number and street of the employee's mailing address as it was entered in box 33 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

12. City:
    Enter the city of the employee's mailing address as it was entered in box 34 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

13. State:
    Enter the state of the employee's mailing address as it was entered in box 35 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

14. Zip:
    Enter the zip code of the employee's mailing address as it was entered in box 36 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

15. Home Phone Number:
    Enter the employee's home telephone number as it was entered in box 30 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

16. Date of Injury:
    Enter the date of injury or illness as it was entered in box 42 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

17. Description of Injury:
Enter a brief description of the injury or illness.

Notice to Employee

18. Enter the date the completed report is due, the periods covered, and where to return the completed report (employer or insurer name and address).

Part II Completed By The Employee

19A. Did You Work or Perform Any Services for Pay or Other Benefit During the Period Stated in the Above Section?
Check either "Yes" or "No."

19B. If "Yes" is checked, complete this section with the name, address, and telephone number(s) of each new employer(s). (Use reverse side of report, if necessary.) **Attach verification of income from each new employer.**

19C. What Type(s) of Work Did You Perform in This Employment?
Indicate the type of work done for each new employer.

19D. Dates Employed
Indicate the dates employed with each new employer.

19E. Are You Still Employed?
Check either "Yes" or "No."

20. Sign and date this form to certify that the information is truthful and accurate.

NOTES

EMPLOYEE'S RETURN TO WORK REPORT

STATE OF MAINE
WORKERS' COMPENSATION BOARD
STATION 27, AUGUSTA, MAINE 04333-0027

PART 1 (COMPLETED BY EMPLOYER/INSURER

1. INSURER FILE NUMBER:	6. SOCIAL SECURITY NUMBER		7. WCB FILE NUMBER:	
2. EMPLOYER NAME:	8. EMPLOYEE LAST NAME:		9. FIRST NAME:	10. M.I.:
3. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:	11. ADDRESS-NUMBER AND STREET:			
4. INSURER NAME:	12. CITY:	13. STATE:	14. ZIP:	15. HOME PHONE:
5. INSURER MAILING ADDRESS:	16. DATE OF INJURY:	17. DESCRIPTION OF INJURY:		

18.

NOTICE TO EMPLOYER/INSURER

THIS REPORT IS SENT TO THE EMPLOYEE WHEN FILING THE MEMORANDUM OF PAYMENT PURSUANT TO 39-A M.R.S.A. § 205 (7).

19.

NOTICE TO EMPLOYEE

IF YOU RETURN TO WORK WITH A NEW EMPLOYER, COMPLETE BOX 20 AND RETURN THIS REPORT TO THE BOARD ADDRESS LISTED ABOVE, THE EMPLOYER LISTED IN BOX 2 AND THE INSURER LISTED IN BOX 4 WITHIN 7 DAYS PURSUANT TO 39-A M.R.S.A. §308 (1).

FAILURE TO COMPLETE AND RETURN THIS REPORT MAY RESULT IN THE DISCONTINUANCE OF YOUR WORKERS' COMPENSATION BENEFITS.

PART 2 (COMPLETED BY THE EMPLOYEE)

20.

COMPLETE THE FOLLOWING INFORMATION (USE REVERSE SIDE IF NECESSARY).

A. NEW EMPLOYER NAME: _____ TELEPHONE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

B. DATE OF HIRE: _____

C. ATTACH VERIFICATION OF INCOME OR LIST ANTICIPATED INCOME:

D. COMMENTS:

20. I HEREBY CERTIFY THAT THE INFORMATION CONTAINED IN THIS REPORT IS TRUTHFUL AND ACCURATE.

_____ _____
EMPLOYEE SIGNATURE DATE

THE STATE OF MAINE DOES NOT DISCRIMINATE ON THE BASIS OF DISABILITY IN ADMISSION TO, ACCESS TO, OR OPERATION OF ITS PROGRAMS, SERVICES, OR ACTIVITIES. THIS FORM IS AVAILABLE IN ALTERNATIVE FORMAT. FOR FURTHER ASSISTANCE, CONTACT THE MAINE WORKERS' COMPENSATION BOARD, ADA COORDINATOR, TELEPHONE: 1-888-801-9087 OR TTY (877) 832-5525

WCB 231 (8/94)

Distribution: (1) Workers' Compensation Board, (2) Employee, (3) Insurer, (4) Employer

EMPLOYEE'S RETURN TO WORK REPORT, WCB-231

Reporting Requirements

Pursuant to 39-A M.R.S.A.§308(1), any person receiving compensation under this Act who returns to employment or engages in new employment after that person's injury shall file a written report of that employment with the Board and that person's previous employer within 7 days of that person's return to work. This report must include the identity of the employee, the employee's employer and the amount of weekly wages or earnings received or to be received by the employee.

Per Rule 8.17, the employer or insurer (which can sometimes be one and the same) shall send the Employee's Return to Work Report to the employee when filing the Memorandum of Payment, WCB-3, pursuant to 39-A M.R.S.A.§205(7).

Distribution

The Employee's Return to Work Report is a four-part form that is to be distributed as follows:

Copy 1 to the Board via e-mail, via fax, or via standard mail at:

Workers' Compensation Board
27 State House Station
Augusta, Maine 04333-0027

Copy 2 to the Employee
Copy 3 to the Insurer
Copy 4 to the Employer

INSTRUCTIONS FOR COMPLETING EMPLOYEE'S RETURN TO WORK REPORT, WCB-231

Part I Completed By Employer/Insurer

1. Insurer File Number:
   Enter the claim administrator claim number as it was entered in box 21 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

2. Employer Name:
   Enter the employer name as it was entered in box 10 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

3. Employer Mailing Address and Phone Number:
   Enter the employer mailing address and phone number as it was entered in boxes 11-15 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

4. Insurer Name:
   Enter the legal name of the insurance company, self-insured or guarantee fund assuming the employer's financial responsibility for this claim as it was entered in box 19 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

5. Insurer Mailing Address:
   Enter the claim administrator mailing address as it was entered in boxes 22-25 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

6. Social Security Number:
   Enter the employee's ID# as it was entered in box 31 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

7. WCB File Number:
   Enter the jurisdiction claim number assigned by the Board to identify this claim.

8. Employee Last Name:
   Enter the employee's last name as it was entered in box 27 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

9. First Name:
   Enter the employee's first name as it was entered in box 28 of the Employer's First Report of Occupational Injury of Disease, WCB-1.

10. M.I.:
    Enter the employee's middle initial as it was entered in box 29 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

11. Address – Number and Street:
    Enter the number and street of the employee's mailing address as it was entered in box 33 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

12. City:
    Enter the city of the employee's mailing address as it was entered in box 34 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

13. State:
    Enter the state of the employee's mailing address as it was entered in box 35 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

14. Zip:
    Enter the zip code of the employee's mailing address as it was entered in box 36 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

15. Home Phone Number:
    Enter the employee's home telephone number as it was entered in box 30 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

16. Date of Injury:
    Enter the date of injury or illness as it was entered in box 42 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

17. Description of Injury:
    Enter a brief description of the injury or illness.

Notice to Employer/Insurer

18. This section notifies the employer/insurer when to send this form to the employee.

Notice to Employee

19. This section notifies the employee or his or her responsibilities.

Part II Completed By The Employee

20. Complete this section, supplying the following information:
    A. Name, address, and telephone number(s) of each new employee.
    B. Date(s) of hire.
    C. Attach verification of income or list anticipated income with each new employer.
    D. Use this space to provide any comments.

21. Sign and date this form to certify that the information is truthful and accurate.

NOTES

EMPLOYEE'S RETURN TO WORK REPORT

STATE OF MAINE
WORKERS' COMPENSATION BOARD
STATION 27, AUGUSTA, MAINE 04333-0027

PART 1 (COMPLETED BY EMPLOYER/INSURER)

1. INSURER FILE NUMBER:	6. SOCIAL SECURITY NUMBER		7. WCB FILE NUMBER:	
2. EMPLOYER NAME:	8. EMPLOYEE LAST NAME:		9. FIRST NAME:	10. M.I.:
3. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:	11. ADDRESS-NUMBER AND STREET:			
4. INSURER NAME:	12. CITY:	13. STATE:	14. ZIP:	15. HOME PHONE:
5. INSURER MAILING ADDRESS:	16. DATE OF INJURY:	17. DESCRIPTION OF INJURY:		

18.

NOTICE TO EMPLOYER/INSURER

THIS REPORT IS SENT TO THE EMPLOYEE WITH THE 21-DAY CERTIFICATE OF DISCONTINUANCE OR REDUCTION OF COMPENSATION OR THE PETITION FOR REVIEW PURSUANT TO RULE 8.15.

19.

NOTICE TO EMPLOYEE

YOUR WEEKLY BENEFITS WILL BE REDUCED OR DISCONTINUED EACH WEEK TO THE AMOUNT SHOWN ON THE CERTIFICATE OF DISCONTINUANCE OR REDUCTION OF COMPENSATION OR PETITION FOR REVIEW. YOU ARE REQUIRED TO PROVIDE DOCUMENTATION TO THE INSURER OF YOUR WEEKLY EARNINGS FOR THE 21-DAY PERIOD OR WHILE THE PETITION FOR REVIEW IS PENDING BEFORE THE WORKERS' COMPENSATION BOARD BY COMPLETING THE INFORMATION IN BOX 20 BELOW. IF YOU FAIL TO PROVIDE DOCUMENTATION, THE REDUCTION SHOWN ON THE CERTIFICATE OF DISCONTINANCE OR REDUCTION OR PETITION FOR REVIEW SHALL REMAIN IN EFFECT AND YOUR BENEFITS WILL NOT BE ADJUSTED.

PART 2 (COMPLETED BY THE EMPLOYEE)

20. **COMPLETE THE FOLLOWING INFORMATION.**

A. INCOME FROM NEW EMPLOYMENT (attach verification):

PAY PERIOD ENDING DATE _____ AMOUNT _____

PAY PERIOD ENDING DATE _____ AMOUNT _____

PAY PERIOD ENDING DATE _____ AMOUNT _____

PAY PERIOD ENDING DATE _____ AMOUNT _____

B. COMMENTS:

21. I HEREBY CERTIFY THAT THE INFORMATION CONTAINED IN THIS REPORT IS TRUTHFUL AND ACCURATE.

_____ _____
EMPLOYEE SIGNATURE DATE

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WCB 231A (1/11)

EMPLOYEE'S RETURN TO WORK REPORT, WCB-231A

Reporting Requirements

Reduction or discontinuance pursuant to §205(9)(B)(1): Pursuant to Rule 8.15, the employer or insurer (which can sometimes be one and the same) must include form WCB-231A (Employee's Return to Work Report) with the 21-day Certificate of Discontinuance or Reduction. Within 14 calendar days after the expiration of the 21-day period, or within 14 days after receipt of documentation from the employee if the documentation is received after the expiration of the 21-day period, the employer/insurer shall file with the Board the documentation it has received along with an amended form WCB-8 which shall also include any necessary adjustments based on the documentation received by the employer/insurer.

Reduction or discontinuance pursuant to § 205(9)(B)(2): Pursuant to Rule 8.15, the employer or insurer (which can sometimes be one and the same) shall send to the employee form WCB-231A (Employee's Return to Work Report) in addition to the Petition for Review. The employer/insurer shall file the actual documented earnings and form WCB-4 showing the adjustment that was made with the Board at the same time it files the Petition for Review. Thereafter, the employer/insurer shall, within 30 days after receipt of the actual documented earnings, file with the Board the actual documentation it has received along with form WCB-4.

INSTRUCTIONS FOR COMPLETING EMPLOYEE'S RETURN TO WORK REPORT, WCB-231A

Part I Completed By The Employer/Insurer

1. Insurer File Number:
   Enter the claim administrator claim number as it was entered in box 21 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

2. Employer Name:
   Enter the employer name as it was entered in box 10 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

3. Employer Mailing Address or Phone Number:
   Enter the employer mailing address and phone number as it was entered in boxes 11-15 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

4. Insurer Name:
   Enter the legal name of the insurance company, self-insured or guarantee fund assuming the employer's financial responsibility for this claim as it was entered in box 19 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

5. Insurer Mailing Address:
   Enter the claim administrator mailing address as it was entered in boxes 22-25 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

6. Social Security Number:
   Enter the employee's ID# as it was entered in box 31 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

7. WCB File Number:
   Enter the jurisdiction claim number assigned by the Board to identify this claim.

8. Employee Last Name:
   Enter the employee's last name as it was entered in box 27 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

9. First Name:
   Enter the employee's first name as it was entered in box 28 of the Employer's First Report of Occupational Injury of Disease, WCB-1.

10. M.I.:
    Enter the employee's middle initial as it was entered in box 29 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

11. Address –Number and Street:
    Enter the number and street of the employee's mailing address as it was entered in box 33 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

12. City:
    Enter the city of employee's mailing address as it was entered in box 34 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

13. State:
    Enter the state of employee's mailing address as it was entered in box 35 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

14. Zip:
    Enter the zip code of the employee's mailing address as it was entered in box 36 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

15. Home Phone:
    Enter the employee's home telephone number as it was entered in box 30 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

16. Date of Injury:
    Enter the date of injury or illness as it was entered in box 42 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

17. Description of Injury:
    Enter a brief description of the injury or illness.

Notice to Employer/Insurer
18. This section notifies the employer/insurer when to send this form to the employee.

Notice to Employee
19. This section notifies the employee or his or her responsibilities.

Part II Completed By The Employee

20. Complete this section, supplying the following information:
    A. Pay period ending date and amount of gross wages earned
    B. Use this space to provide any comments.

21. Sign and date this form to certify that the information is truthful and accurate.

NOTES

REQUEST FOR EXPEDITED PROCEEDING

STATE OF MAINE
WORKERS' COMPENSATION BOARD
STATION 27, AUGUSTA, MAINE 04333-0027

1. INSURER FILE NUMBER:	6. SOCIAL SECURITY NUMBER		7. WCB FILE NUMBER:	
2. EMPLOYER NAME:	8. EMPLOYEE LAST NAME:		9. FIRST NAME:	10. M.I.:
3. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:	11. ADDRESS-NUMBER AND STREET:			
4. INSURER NAME:	12. CITY:	13. STATE:	14. ZIP:	15. HOME PHONE:
5. INSURER MAILING ADDRESS:	16. DATE OF INJURY:	17. DESCRIPTION OF INJURY:		

18 A. ☐ REQUEST FOR PROVISIONAL ORDER AND EXPEDITED PROCEEDING PURSUANT TO 39-A M.R.S.A. §205(9)(E) AND RULE 1.3.

B. ☐ REQUEST FOR EXPEDITED PROCEEDING PURSUANT TO 39-A M.R.S.A. §315.

C. ☐ REQUEST FOR EXPEDITED PROCEEDING BASED ON EXTREME FINANCIAL HARDSHIP. EXPLANATION:

ATTACH THIS REQUEST TO THE FRONT OF THE APPROPRIATE PETITION AND SUPPORTING DOCUMENTS.

19. WHEREFORE, I HEREBY REQUEST AN EXPEDITED PROCEEDING.

_____ _____-
SIGNATURE OF REQUESTING PARTY DATE

NAME AND ADDRESS OF ATTORNEY (IF ANY):

REPRESENTING (CHECK ONE):

☐ EMPLOYEE ☐ EMPLOYER

ASSISTANCE IS AVALABLE AT THE BOARD'S REGIONAL OFFICES:

AUGUSTA
24 STONE ST
AUGUSTA, ME 04330-5220
287-2168
1-800-400-6854

BANGOR
106 HOGAN RD.
BANGOR, ME 04401-5640
941-4550
1-800-400-6856

CARIBOU
ONE VAUGHN PLACE
43 HATCH DR, STE 305
CARIBOU, ME 04736
498-6428
1-800-400-6855

LEWISTON
36 MOLLISON WAY
LEWISTON, ME 04240-5811
753-7700
1-800-400-6857

PORTLAND
62 ELM ST
PORTLAND, ME 04101-6858
822-0840
1-800-400-6858

IWAH WCB-250 (8-94)

THE STATE OF MAINE DOES NOT DISCRIMINATE ON THE BASIS OF DISABILITY IN ADMISSION TO, ACCESS TO, OR OPERATION OF ITS PROGRAMS, SERVICES, OR ACTIVITIES. THIS FORM IS AVAILABLE IN ALTERNATIVE FORMAT. FOR FURTHER ASSISTANCE, CONTACT THE MAINE WORKERS' COMPENSATION BOARD, ADA COORDINATOR, TELEPHONE: 1-888-801-9087 OR TTY (877) 832-5525

REQUEST FOR EXPEDITED PROCEEDING, WCB-250

Reporting Requirements

The Request for Expedited Proceeding (WCB-250) shall be attached to the front of the appropriate Petition and supporting documents (Rule 1.9).

INSTRUCTIONS FOR COMPLETING REQUEST FOR EXPEDITED PROCEEDING, WCB-250

Identifying Information

1. Insurer File Number:
   Enter the claim administrator claim number as it was entered in box 21 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

2. Employer Name:
   Enter the employer name as it was entered in box 10 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

3. Employer Mailing Address and Phone Number:
   Enter the employer mailing address and phone number as it was entered in boxes 11-15 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

4. Insurer Name:
   Enter the legal name of the insurance company, self-insured or guarantee fund assuming the employer's financial responsibility for this claim as it was entered in box 19 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

5. Insurer Mailing Address:
   Enter the claim administrator mailing address as it was entered in boxes 22-25 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

6. Social Security Number:
   Enter the employee's ID # as it was entered in box 31 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

7. WCB File Number:
   Enter the jurisdiction claim number assigned by the Board to identify this claim.

8. Employee Last Name:
   Enter the employee's last name as it was entered in box 27 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

9. First Name:
   Enter the employee's first name as it was entered in box 28 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

10. M.I.:
    Enter the employee's middle initial as it was entered in box 29 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

11. Address – Number and Street:
    Enter the number and street of the employee's mailing address as it was entered in box 33 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

12. City:
    Enter the city of the employee's mailing address as it was entered in box 34 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

13. State:
    Enter the state of the employee's mailing address as it was entered in box 35 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

14. Zip:
    Enter the zip code of the employee's mailing address as it was entered in box 36 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

15. Home Phone Number:
    Enter the employee's home phone number as it was entered in box 30 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

16. Date of Injury:
    Enter the date of injury or illness as it was entered in box 42 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

17. Description of Injury:
    Enter a brief description of the injury or illness.

Request for Provisional Order and Expedited Proceeding

18. Check the appropriate box.

Request an Expedited Proceeding

19. Sign and date the form
    Provide the name and mailing address of the preparer's legal representative (if any). Check the appropriate box to show who is represented.

NOTES

PETITION FOR REVIEW OF INCAPACITY

STATE OF MAINE
WORKERS' COMPENSATION BOARD
27 STATE HOUSE STATION
AUGUSTA, MAINE 04333-0027

PETITIONER

NAME: _____

STREET/.P.O.BOX: _____

CITY, STATE, ZIP: _____

TELEPHONE NUMBER: _____

EMPLOYEE SOCIAL SECURITY NUMBER: _____

BOARD FILE NUMBER: (IF KNOWN)

RESPONDENT

NAME:

STREET/P.O.BOX: _____

CITY, STATE, ZIP:

RESPONDENT

NAME: _____

STREET/P.O. BOX :

CITY, STATE, ZIP:

1. On _____ (MONTH DAY YEAR), _____ (EMPLOYEE NAME)
   experienced a work-related injury while working for _____ (EMPLOYER NAME).
2. Compensation of $ _____ per week is being paid for _____ (PARTIAL, TOTAL (SELECT ONE)) incapacity.
3. The employee's incapacity has _____ (INCREASED, DECREASED, ENDED (SELECT ONE)).

WHEREFORE, the petitioner asks the Board to review the amount of compensation paid pursuant to 39-A M.R.S.A.

_____
SIGNATURE OF PETITIONER

DATED: _____ (MONTH DAY YEAR)

EMPLOYEE FILING INSTRUCTIONS

1. Mail original petition to the Workers= Compensation Board at the above address by regular mail.
2. Mail one (1) copy **by certified mail, return receipt requested** to the insurance company.
3. Mail one (1) copy **by certified mail, return receipt requested** to the employer.
4. Keep one (1) copy for yourself and keep the green certified mail cards when returned to you by the U.S. Post Office.

_____
NAME OF PETITIONER'S ATTORNEY OR ADVOCATE (IF ANY)

STREET/P.O. BOX

CITY, STATE, ZIP

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WCB-120 (6/98)

PETITION FOR REVIEW OF INCAPACITY, WCB-120

Any interested party may file this petition to request a determination of an injured employee's entitlement to ongoing weekly compensation.

Use the following distribution requirements only when this form is being prepared and filed by the injured employee or their representative.
(Distribution requirements for the employer or its representative follow the instructions.)

Distribution

The Petition for Review of Incapacity, WCB-120, is to be distributed as follows:

Original — Mail the original petition to the Board at the following address by regular mail:

Workers' Compensation Board
27 State House Station
Augusta, Maine 04333-0027

Copy 1 — Mail one copy of the petition **by certified mail, return receipt requested** to the insurance company or 3rd-party administrator (if there is an insurance company or 3rd-party administrator representing the employer).

Copy 2 — Mail one copy of the petition **by certified mail, return receipt requested** to the employer.

Copy 3 — Keep one copy of the petition for your records. Also keep the green certified mail cards (for the copies sent to the insurance company or 3rd-party administrator and the employer) when the U.S. Post Office returns them to you.

INSTRUCTIONS FOR COMPLETING PETITION FOR REVIEW OF INCAPACITY, WCB-120

Petitioner

Name
Enter the injured employee's first name, middle initial and last name.

Street/P.O. Box
Enter the injured employee's mailing address.

City, State, Zip

Enter the city, state and zip code of the injured employee's mailing address.

Telephone Number

Enter the injured employee's home telephone number, including the area code.

Employee Social Security Number

Enter the injured employee's social security number.

Board File Number

Enter the jurisdiction claim number assigned by the Board to identify this claim.

Respondent

Name

Enter the employer's name.

Street/P.O. Box

Enter the employer's mailing address.

City, State, Zip

Enter the city, state and zip code of the employer's mailing address.

Respondent

Name

Enter the name of the insurance company or 3rd-party administrator (if there is one) who represents the employer's interest in this workers' compensation claim.

Street/P.O. Box

Enter the insurance company or 3rd-party administrator's mailing address.

City, State, Zip

Enter the city, state and zip code of the insurance company or 3rd-party administrator's mailing address.

1. On ___/___/____, _____ experienced a work-related injury while working for _____.
   MM DD YYYY Employee Name Employer Name

   Enter the date (month, day, year) of the employee's injury on the first line.
   Enter the injured employee's name (first name, middle initial and last name) on the second line.
   Enter the employer's name on the third line.

2. Compensation of $_____ per week is being paid for _____ incapacity.
   Partial, Total (Select One)

   Enter the dollar amount of the weekly workers' compensation benefit currently being received by the injured employee on the first line. If the weekly benefit differs from week to week, enter the word "varying" on this line.

   If the amount shown on the first line represents the full amount of benefits allowed for a full week of lost earnings, enter the word "total" on the second line. If the amount shown on the first line does not represent the full amount of benefits allowed for a full week of lost earnings, enter the word "partial" on this line. If the amount shown on the first line is $0.00, do not complete this line.

3. The employee's incapacity has _____.
   Increased, Decreased, Ended (Select One)

   Enter the word (increased, decreased or ended) which best describes the change in the injured employee's incapacity or ability to earn that has prompted the filing of this form.

_____
Signature of Petitioner

This line must be signed by the injured employee or their representative.

Dated: ___/___/____
MM DD YYYY

Enter the date (month, day, year) that this form was signed by the injured employee or their representative.

_____
Name of Petitioner's Attorney or Advocate (If Any)

If the injured employee is represented by an attorney or advocate, enter the name of the employee's attorney or advocate.

_____
Street/P.O. Box

Enter the attorney or advocate's mailing address.

_____
City, State, Zip

Enter the city, state and zip code of the attorney or advocate's mailing address.

Use the following distribution requirements only when this form is being prepared and filed by the employer, insurer, 3rd-party administrator, or its representative. (Distribution requirements for the employee or their representative precede the instructions.)

Distribution

The Petition for Review of Incapacity, WCB-120, is to be distributed as follows:

Original	Mail the original petition to the Board at the following address by regular mail: Workers' Compensation Board 27 State House Station Augusta, Maine 04333-0027
Copy 1	Mail one copy of the petition **by certified mail, return receipt requested** to the injured employee.
Copy 2	If this petition is being filed by the insurer, 3rd-party administrator, employer attorney or employer advocate, mail one copy of the petition **by certified mail, return receipt requested** to the employer.
Copy 3	If the employee is represented by an attorney or advocate, mail one copy of the petition **by certified mail, return receipt requested** to the attorney or advocate.
Copy 4	Keep one copy of the petition for your records. Also keep the green certified mail cards (for the copies sent to the employee, employer and the employee's attorney) when the U.S. Post Office returns them to you.

NOTES

EMPLOYEE PETITION FOR REVIEW OF INCAPACITY AND REQUEST FOR PROVISIONAL ORDER

STATE OF MAINE
WORKERS' COMPENSATION BOARD
27 STATE HOUSE STATION
AUGUSTA, MAINE 04333-0027

EMPLOYEE

NAME: _____

STREET/.P.O. BOX: _____

CITY, STATE, ZIP: _____

TELEPHONE NUMBER: _____

EMPLOYEE SOCIAL SECURITY NUMBER: _____

BOARD FILE NUMBER: _____ (IF KNOWN)

EMPLOYER

NAME: _____

STREET/P.O. BOX: _____

CITY, STATE, ZIP: _____

INSURANCE COMPANY

NAME: _____

STREET/P.O. BOX: _____

CITY, STATE, ZIP: _____

1. On _____ (MONTH DAY YEAR), _____ (EMPLOYEE NAME) experienced a work-related injury while working for _____ (EMPLOYER NAME).

2. Compensation of $ _____ per week is being paid for _____ (PARTIAL, TOTAL (SELECT ONE)) incapacity.

3. Compensation benefits were _____ (REDUCED, DISCONTINUED (SELECT ONE)) as of _____ (MONTH, DAY YEAR).

4. The employer should reinstate the employee=s weekly compensation benefits for the following reasons:
(Attach recent medical reports and/or other documents to support this petition.)

_____

_____

_____

WHEREFORE, the employee asks that the Board issue a provisional order reinstating compensation benefits until a formal decision is ordered pursuant to 39-A M.R.S.A. ∋205.

_____
SIGNATURE OF EMPLOYEE

DATED: _____
MONTH DAY YEAR

NAME OF EMPLOYEE'S ATTORNEY OR ADVOCATE (IF ANY)

STREET/P.O. BOX

CITY, STATE, ZIP

FILING INSTRUCTIONS

1. Mail original petition to the Workers= Compensation Board at the above address by regular mail.
2. Mail one (1) copy **by certified mail, return receipt requested** to the insurance company.
3. Mail one (1) copy **by certified mail, return receipt requested** to the employer.
4. Keep one (1) copy for yourself and keep the green certified mail cards when returned to you by the U.S. Post Office.

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WCB-121 (6/98)

EMPLOYEE PETITION FOR REVIEW OF INCAPACITY AND REQUEST FOR PROVISIONAL ORDER, WCB-121

An injured employee or their representative may file this petition to request a determination of the injured employee's entitlement to ongoing weekly compensation and to request a Provisional Order to reinstate their weekly benefits when they disagree with the employer/insurer's reduction or discontinuance of those benefits.

Distribution

The Employee Petition for Review of Incapacity and Request for Provisional Order, WCB-121, is to be distributed as follows:

Original — Mail the original petition to the Board at the following address by regular mail:

Workers' Compensation Board
27 State House Station
Augusta, Maine 04333-0027

Copy 1 — Mail one copy of the petition **by certified mail, return receipt requested** to the insurance company or 3rd-party administrator (if there is an insurance company or 3rd-party administrator representing the employer).

Copy 2 — Mail one copy of the petition **by certified mail, return receipt requested** to the employer.

Copy 3 — Keep one copy of the petition for your records. Also keep the green certified mail cards (for the copies sent to the insurance company or 3rd-party administrator and the employer) when the U.S. Post Office returns them to you.

INSTRUCTIONS FOR COMPLETING EMPLOYEE PETITION FOR REVIEW OF INCAPACITY AND REQUEST FOR PROVISIONAL ORDER, WCB-121

Employee

Name

Enter the injured employee's first name, middle initial and last name.

Street/P.O. Box
Enter the injured employee's mailing address.

City, State, Zip
Enter the city, state and zip code of the injured employee's mailing address.

Telephone Number
Enter the injured employee's home telephone number, including the area code.

Employee Social Security Number
Enter the injured employee's social security number.

Board File Number
Enter the jurisdiction claim number assigned by the Board to identify this claim.

Employer

Name
Enter the employer's name.

Street/P.O. Box
Enter the employer's mailing address.

City, State, Zip
Enter the city, state and zip code of the employer's mailing address.

Insurance Company

Name
Enter the name of the insurance company or 3rd-party administrator (if there is one) who represents the employer's interest in this workers' compensation claim.

Street/P.O. Box
Enter the insurance company or 3rd-party administrator's mailing address.

City, State, Zip
Enter the city, state and zip code of the insurance company or 3rd-party administrator's mailing address.

1. On ___/___/____, _____ experienced a work-related injury while working for _____.
   MM DD YYYY Employee Name Employer Name
   Enter the date (month, day, year) of the employee's injury on the first line.
   Enter the injured employee's name (first name, middle initial and last name) on the second line.

   Enter the employer's name on the third line.

2. Compensation of $_____ per week is being paid for _____ incapacity.
   Partial, Total (Select One)

   Enter the dollar amount of the weekly workers' compensation benefit currently being received by the injured employee on the first line. If the weekly benefit differs from week to week, enter the word "varying" on this line.
   If the amount shown on the first line represents the full amount of benefits allowed for a full week of lost earnings, enter the word "total" on the second line. If the amount shown on the first line does not represent the full amount of benefits allowed for a full week of lost earnings, enter the word "partial" on this line. If the amount shown on the first line is $0.00, do not complete this line.

3. Compensation benefits were _____ as of ___/___/____.
   Reduced, Discontinued (Select One) MM DD YYYY

   Enter the word (reduced or discontinued) which best describes the change in the injured employee's weekly benefits that has prompted the filing of this form on the first line.
   Enter the effective date (month, day, year) of the reduction or discontinuance of weekly benefits on the second line.

4. The employer should reinstate the employee's weekly compensation benefits for the following reasons:

   Enter the reason(s) why you believe that the injured employee's benefits should be restored. Attach copies of any recent medical reports and/or other documents that support this petition.

_____
Signature of Employee

This line must be signed by the injured employee or their representative.

Dated: ___/___/____
MM DD YYYY

Enter the date (month, day, year) that this form was signed by the injured employee or their representative.

_____
Name of Employee's Attorney or Advocate (If Any)

If the injured employee is represented by an attorney or advocate, enter the name of the employee's attorney or advocate.

_____
Street/P.O. Box

Enter the attorney or advocate's mailing address.

_____
City, State, Zip

Enter the city, state and zip code of the attorney or advocate's mailing address.

NOTES

PETITION TO DETERMINE AVERAGE WEEKLY WAGE

STATE OF MAINE
WORKERS' COMPENSATION BOARD
27 STATE HOUSE STATION
AUGUSTA, MAINE 04333-0027

PETITIONER

NAME: _____

STREET/P.O. BOX: _____

CITY, STATE, ZIP: _____

TELEPHONE NUMBER: _____

EMPLOYEE SOCIAL SECURITY NUMBER: _____

BOARD FILE NUMBER: _____
(IF KNOWN)

RESPONDENT

NAME: _____

STREET/P.O. BOX: _____

CITY, STATE, ZIP: _____

RESPONDENT

NAME: _____

STREET/P.O. BOX: _____

CITY, STATE, ZIP: _____

On _____, _____ , _____
MONTH DAY YEAR EMPLOYEE NAME

experienced a work-related injury while working for _____.
EMPLOYER NAME

WHEREFORE, the petitioner asks the Board to determine the correct average weekly wage pursuant to 39-A M.R.S.A.

_____

DATED: _____
MONTH DAY YEAR

_____
SIGNATURE OF PETITIONER

EMPLOYEE FILING INSTRUCTIONS

1. Mail original petition to the Workers= Compensation Board at the above address by regular mail.
2. Mail one (1) copy **by certified mail, return receipt requested** to the insurance company.
3. Mail one (1) copy **by certified mail, return receipt requested** to the employer.
4. Keep one (1) copy for yourself and keep the green certified mail cards when returned to you by the U.S. Post Office.

NAME OF PETITIONER'S ATTORNEY OR ADVOCATE (IF ANY)

STREET/P.O. BOX

CITY, STATE, ZIP

THE STATE OF MAINE DOES NOT DISCRIMINATE ON THE BASIS OF DISABILITY IN ADMISSION TO, ACCESS TO, OR OPERATION OF ITS PROGRAMS, SERVICES, OR ACTIVITIES. THIS FORM IS AVAILABLE IN ALTERNATIVE FORMAT. FOR FURTHER ASSISTANCE, CONTACT THE MAINE WORKERS' COMPENSATION BOARD, ADA COORDINATOR, TELEPHONE: 1-888-801-9087 OR TTY (877) 832-5525

WCB-122 (06/98)

PETITION TO DETERMINE AVERAGE WEEKLY WAGE, WCB-122

Any interested party may file this petition to request a determination of the injured employee's average weekly wage.

Use the following distribution requirements only when this form is being prepared and filed by the injured employee or their representative.
(Distribution requirements for the employer or its representative follow the instructions.)

Distribution

The Petition to Determine Average Weekly Wage, WCB-122, is to be distributed as follows:

Original — Mail the original petition to the Board at the following address by regular mail:

Workers' Compensation Board
27 State House Station
Augusta, Maine 04333-0027

Copy 1 — Mail one copy of the petition **by certified mail, return receipt requested** to the insurance company or 3rd-party administrator (if there is an insurance company or 3rd-party administrator representing the employer).

Copy 2 — Mail one copy of the petition **by certified mail, return receipt requested** to the employer.

Copy 3 — Keep one copy of the petition for your records. Also keep the green certified mail cards (for the copies sent to the insurance company or 3rd-party administrator and the employer) when the U.S. Post Office returns them to you.

INSTRUCTIONS FOR COMPLETING PETITION TO DETERMINE AVERAGE WEEKLY WAGE, WCB-122

Petitioner

Name

Enter the injured employee's first name, middle initial and last name.

Street/P.O. Box

Enter the injured employee's mailing address.

City, State, Zip

Enter the city, state and zip code of the injured employee's mailing address.

Telephone Number

Enter the injured employee's home telephone number, including the area code.

Employee Social Security Number

Enter the injured employee's social security number.

Board File Number

Enter the jurisdiction claim number assigned by the Board to identify this claim.

Respondent

Name

Enter the employer's name.

Street/P.O. Box

Enter the employer's mailing address.

City, State, Zip

Enter the city, state and zip code of the employer's mailing address.

Respondent

Name

Enter the name of the insurance company or 3rd-party administrator (if there is one) who represents the employer's interest in this workers' compensation claim.

Street/P.O. Box

Enter the insurance company or 3rd-party administrator's mailing address.

City, State, Zip

Enter the city, state and zip code of the insurance company or 3rd-party administrator's mailing address.

On ___/___/____, _____ experienced a work-related injury while working for _____.
MM DD YYYY Employee Name Employer Name

Enter the date (month, day, year) of the employee's injury on the first line.
Enter the injured employee's name (first name, middle initial and last name) on the second line.

Enter the employer's name on the third line.

_____
Signature of Petitioner

This line must be signed by the injured employee or their representative.

Dated: ___/___/____
MM DD YYYY

Enter the date (month, day, year) that this form was signed by the injured employee or their representative.

_____
Name of Petitioner's Attorney or Advocate (If Any)

If the injured employee is represented by an attorney or advocate, enter the name of the employee's attorney or advocate.

_____
Street/P.O. Box

Enter the attorney or advocate's mailing address.

_____
City, State, Zip

Enter the city, state and zip code of the attorney or advocate's mailing address.

Use the following distribution requirements only when this form is being prepared and filed by the employer, insurer, 3rd-party administrator, or its representative. (Distribution requirements for the employee or their representative precede the instructions.)

Distribution

The Petition to Determine Average Weekly Wage, WCB-122, is to be distributed as follows:

Original	Mail the original petition to the Board at the following address by regular mail: Workers' Compensation Board 27 State House Station Augusta, Maine 04333-0027
Copy 1	Mail one copy of the petition **by certified mail, return receipt requested** to the injured employee.
Copy 2	If this petition is being filed by the insurer, 3rd-party administrator, employer attorney or employer advocate, mail one copy of the petition **by certified mail, return receipt requested** to the employer.
Copy 3	If the employee is represented by an attorney or advocate, mail one copy of the petition **by certified mail, return receipt requested** to the attorney or advocate.
Copy 4	Keep one copy of the petition for your records. Also keep the green certified mail cards (for the copies sent to the employee, employer and the employee's attorney) when the U.S. Post Office returns them to you.

NOTES

PETITION FOR AWARD OF COMPENSATION

STATE OF MAINE
WORKERS' COMPENSATION BOARD
27 STATE HOUSE STATION
AUGUSTA, MAINE 04333-0027

PETITIONER

NAME: _____

STREET/P.O. BOX: _____

CITY, STATE, ZIP: _____

TELEPHONE NUMBER: _____

EMPLOYEE SOCIAL SECURITY NUMBER: _____

BOARD FILE NUMBER: _____
(IF KNOWN)

RESPONDENT

NAME: _____

STREET/P. O. BOX: _____

CITY, STATE, ZIP: _____

RESPONDENT

NAME:

STREET/P.O. BOX:
CITY, STATE, ZIP:

1. On _____,
   MONTH DAY YEAR EMPLOYEE NAME
   experienced a work-related injury while working for _____.
   EMPLOYER NAME

2. Describe how the injury occurred:

   _____

3. List body part(s) injured: _____

   _____

   _

4. The employee _____ lose time from work.
   DID, DID NOT (SELECT ONE)

WHEREFORE, the petitioner asks the Board to order the following benefits pursuant to 39-A M.R.S.A. (check all that apply):

_____ Weekly lost time benefits
_____ Protection of the Act
_____ Specific loss benefits

_____
SIGNATURE OF PETITIONER

DATED: _____
MONTH DAY YEAR

EMPLOYEE FILING INSTRUCTIONS

1. Mail original petition to the Workers= Compensation Board at the above address by regular mail.
2. Mail one (1) copy **by certified mail, return receipt requested** to the insurance company.
3. Mail one (1) copy **by certified mail, return receipt requested** to the employer.
4. Keep one (1) copy for yourself and keep the green certified mail cards when returned to you by the U.S. Post Office.

NAME OF PETITIONER'S ATTORNEY OR ADVOCATE (IF ANY)

STREET/P.O. BOX

CITY, STATE, ZIP

THE STATE OF MAINE DOES NOT DISCRIMINATE ON THE BASIS OF DISABILITY IN ADMISSION TO, ACCESS TO, OR OPERATION OF ITS PROGRAMS, SERVICES, OR ACTIVITIES. THIS FORM IS AVAILABLE IN ALTERNATIVE FORMAT. FOR FURTHER ASSISTANCE, CONTACT THE MAINE WORKERS' COMPENSATION BOARD, ADA COORDINATOR, TELEPHONE: 1-888-801-9087 OR TTY (877) 832-5525

WCB-140 (06/98)

PETITION FOR AWARD OF COMPENSATION, WCB-140

Any interested party may file this petition to request a determination of an employer's responsibility for the payment of compensation to an injured employee (§305).

Use the following instructions only when this form is being prepared and filed by the injured employee or their representative. (For employer or employer representative instructions, please contact a Claims Resolution Specialist at the nearest office of the Board.)

Distribution

The Petition for Award of Compensation, WCB-140, is to be distributed as follows:

Original — Mail the original petition to the Board at the following address by regular mail:

Workers' Compensation Board
27 State House Station
Augusta, Maine 04333-0027

Copy 1 — Mail one copy of the petition **by certified mail, return receipt requested** to the insurance company or 3rd-party administrator (if there is an insurance company or 3rd-party administrator representing the employer).

Copy 2 — Mail one copy of the petition **by certified mail, return receipt requested** to the employer.

Copy 3 — Keep one copy of the petition for your records. Also keep the green certified mail cards (for the copies sent to the insurance company or 3rd-party administrator and the employer) when the U.S. Post Office returns them to you.

INSTRUCTIONS FOR COMPLETING PETITION FOR AWARD OF COMPENSATION, WCB-140

Petitioner

Name
Enter the injured employee's first name, middle initial and last name.

Street/P.O. Box
Enter the injured employee's mailing address.

City, State, Zip
Enter the city, state and zip code of the injured employee's mailing address.

Telephone Number
Enter the injured employee's home telephone number, including the area code.

Employee Social Security Number
Enter the injured employee's social security number.

Board File Number
Enter the jurisdiction claim number assigned by the Board to identify this claim.

Respondent

Name
Enter the employer's name.

Street/P.O. Box
Enter the employer's mailing address.

City, State, Zip
Enter the city, state and zip code of the employer's mailing address.

Respondent

Name
Enter the name of the insurance company or 3rd-party administrator (if there is one) who represents the employer's interest in this workers' compensation claim.

Street/P.O. Box
Enter the insurance company or 3rd-party administrator's mailing address.

City, State, Zip
Enter the city, state and zip code of the insurance company or 3rd-party administrator's mailing address.

1. On ___/___/____, _____ experienced a work-related injury while working for _____.
   MM DD YYYY Employee Name Employer Name
   Enter the date (month, day, year) of the employee's injury on the first line.
   Enter the injured employee's name (first name, middle initial and last name) on the second line.
   Enter the employer's name on the third line.

2. Describe how the injury occurred:
   Enter a brief description of how the injury occurred.

3. List body part(s) injured:

Enter a list of the body parts affected by the injury or illness. When specifying a part of the body, be sure to indicate whether it is "left" or "right." When the injury involves fingers or toes, use the numbers one through five to describe the body part. (One is the thumb or big toe; five is the little finger or little toe.)

4. The employee_____ lose time from work.
Did, Did Not (Select One)

If the injured employee has lost a day or more from work, enter "did." If the injured employee has not lost a day or more from work, enter "did not."

WHEREFORE, the petitioner asks the Board to order the following benefits pursuant to 39-A M.R.S.A. (check all that apply):

___ Weekly lost time benefits
___ Protection of the Act
___ Specific loss benefits

If the injured employee has been incapacitated for more than seven days, check "Weekly lost time benefits."

If the injured employee seeks to protect their rights under the Workers' Compensation Act, check "Protection of the Act."

If the injured employee has suffered a dismemberment or the total loss of an eye due to the work-related injury, check "Specific loss benefits."

_____
Signature of Petitioner

This line must be signed by the injured employee or their representative.

Dated: ___/___/____
MM DD YYYY

Enter the date (month, day, year) that this form was signed by the injured employee or their representative.

_____
Name of Petitioner's Attorney or Advocate (If Any)

If the injured employee is represented by an attorney or advocate, enter the name of the employee's attorney or advocate.

_____
Street/P.O. Box

Enter the attorney or advocate's mailing address.

_____
City, State, Zip

Enter the city, state and zip code of the attorney or advocate's mailing address.

NOTES

PETITION FOR AWARD OF COMPENSATION - FATAL

STATE OF MAINE
WORKERS' COMPENSATION BOARD
27 STATE HOUSE STATION
AUGUSTA, MAINE 04333-0027

PETITIONER	EMPLOYER
NAME: _____	NAME: _____
STREET/P.O. BOX: _____	STREET/P.O. BOX: _____
CITY, STATE, ZIP: _____	CITY, STATE, ZIP: _____
TELEPHONE NUMBER: _____	
	INSURANCE COMPANY
EMPLOYEE SOCIAL SECURITY NUMBER: _____	NAME: _____
	STREET/P.O. BOX: _____
BOARD FILE NUMBER: _____ (IF KNOWN)	CITY, STATE, ZIP: _____

1. On _____ (MONTH DAY YEAR), _____ (NAME OF DECEASED EMPLOYEE)
   experienced a work-related injury while working for _____ (EMPLOYER NAME).
2. Describe how the injury occurred:
3. Death resulted on: _____ (MONTH DAY YEAR).
4. Petitioner relationship: _____.
5. List the dependent(s) and respective date(s) of birth: _____

WHEREFORE, the petitioner asks the Board to award the payment of compensation pursuant to 39-A M.R.S.A. _____

DATED: _____ (MONTH DAY YEAR)

NAME OF PETITIONER'S ATTORNEY OR ADVOCATE (IF ANY)

STREET/P.O. BOX

CITY, STATE, ZIP

FILING INSTRUCTIONS

1. Mail original petition to the Workers= Compensation Board at the above address by regular mail.
2. Mail one (1) copy **by certified mail, return receipt requested** to the insurance company.
3. Mail one (1) copy **by certified mail, return receipt requested** to the employer.
4. Keep one (1) copy for yourself and keep the green certified mail cards when returned to you by the U.S. Post Office.

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WCB-150 (06/98)

PETITION FOR AWARD OF COMPENSATION – FATAL, WCB-150

Any interested party may file this petition to request a determination of an employer's responsibility for the payment of compensation to the dependent(s) of an injured employee who has died as a result of their work-related injury.

This petition may be filed no later than one year after the employee's death.

Distribution

The Petition for Award of Compensation - Fatal, WCB-150, is to be distributed as follows:

Original — Mail the original petition to the Board at the following address by regular mail:

Workers' Compensation Board
27 State House Station
Augusta, Maine 04333-0027

Copy 1 — Mail one copy of the petition **by certified mail, return receipt requested** to the insurance company or 3rd-party administrator (if there is an insurance company or 3rd-party administrator representing the employer).

Copy 2 — Mail one copy of the petition **by certified mail, return receipt requested** to the employer.

Copy 3 — Keep one copy of the petition for your records. Also keep the green certified mail cards (for the copies sent to the insurance company or 3rd-party administrator and the employer) when the U.S. Post Office returns them to you.

INSTRUCTIONS FOR COMPLETING PETITION FOR AWARD OF COMPENSATION – FATAL, WCB-150

Petitioner

Name

Enter the first name, middle initial and last name of the person filing this petition. (This is usually either the dependent or their legal guardian.)

Street/P.O. Box

Enter the petitioner's mailing address.

City, State, Zip

Enter the city, state and zip code of the petitioner's mailing address.

Telephone Number

Enter the petitioner's telephone number, including the area code.

Employee Social Security Number

Enter the deceased employee's social security number.

Board File Number

Enter the jurisdiction claim number assigned by the Board to identify this claim.

Employer

Name

Enter the employer's name.

Street/P.O. Box

Enter the employer's mailing address.

City, State, Zip

Enter the city, state and zip code of the employer's mailing address.

Insurance Company

Name

Enter the name of the insurance company or 3rd-party administrator (if there is one) who represents the employer's interest in this workers' compensation claim.

Street/P.O. Box

Enter the insurance company or 3rd-party administrator's mailing address.

City, State, Zip

Enter the city, state and zip code of the insurance company or 3rd-party administrator's mailing address.

1. On ___/___/____, _____ experienced a work-related injury while working for _____.
   MM DD YYYY, Name of Deceased Employee; Employer Name

   Enter the date (month, day, year) of the deceased employee's injury on the first line.
   Enter the deceased employee's name (first name, middle initial and last name) on the second line.
   Enter the employer's name on the third line.

2. Describe how the injury occurred:

   Enter a brief description of how the injury happened.

3. Death resulted on: ___/___/____.
   MM DD YYYY

   Enter the date (month, day, year) of the injured employee's death.

4. Petitioner relationship:

   Enter the relationship of the petitioner (listed above) to the deceased employee. For example: spouse, ex-spouse, child, parent, sibling, friend, attorney, etc.

5. List the dependent(s) and respective date(s) of birth:

   Enter the name(s) and date(s) of birth of the person(s) who was/were financially dependent upon the injured employee at the time of his/her death.

_____
Signature of Petitioner

This line must be signed by the petitioner or their representative.

Dated: ___/___/____
MM DD YYYY

Enter the date (month, day, year) that this form was signed by the petitioner or their representative.

_____
Name of Petitioner's Attorney or Advocate (If Any)

If the petitioner is represented by an attorney or advocate, enter the name of the petitioner's attorney or advocate.

_____
Street/P.O. Box

Enter the attorney or advocate's mailing address.

_____
City, State, Zip

Enter the city, state and zip code of the attorney or advocate's mailing address.

NOTES

PETITION FOR AWARD OF COMPENSATION - OCCUPATIONAL DISEASE LAW

STATE OF MAINE
WORKERS' COMPENSATION BOARD
27 STATE HOUSE STATION
AUGUSTA, MAINE 04333-0027

EMPLOYEE

NAME: _____

STREET/P.O. BOX: _____

CITY, STATE, ZIP: _____

TELEPHONE NUMBER: _____

EMPLOYEE SOCIAL SECURITY NUMBER: _____

BOARD FILE NUMBER: _____
(IF KNOWN)

EMPLOYER

NAME: _____

STREET/P.O. BOX: _____

CITY, STATE, ZIP: _____

INSURANCE COMPANY

NAME: _____

STREET/P.O. BOX:

CITY,STATE, ZIP:

1. On _____ (MONTH DAY YEAR), _____ (EMPLOYEE NAME)
developed a work-related disease while working for _____ (EMPLOYER NAME).
2. Date of last exposure: _____ (MONTH DAY YEAR).
3. Date of incapacity: _____ (MONTH DAY YEAR).
4. Date employment ceased: _____ (MONTH DAY YEAR).
5. Describe how the exposure occurred:
6. Describe the occupational disease:
7. List the body part(s) affected:

WHEREFORE, the employee asks the Board to award the payment of compensation pursuant to 39-A M.R.S.A.

_____
SIGNATURE OF EMPLOYEE

DATED: _____
MONTH DAY YEAR

FILING INSTRUCTIONS

1. Mail original petition to the Workers= Compensation Board at the above address by regular mail.
2. Mail one (1) copy **by certified mail, return receipt requested** to the insurance company.
3. Mail one (1) copy **by certified mail, return receipt requested** to the employer.
4. Keep one (1) copy for yourself and keep the green certified mail cards when returned to you by the U. S. Post Office.

NAME OF EMPLOYEE'S ATTORNEY OR ADVOCATE (IF ANY)

STREET/P.O. BOX

CITY, STATE, ZIP

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WCB-160 (06/98)

PETITION FOR AWARD OF COMPENSATION – OCCUPATIONAL DISEASE LAW, WCB-160

An injured employee or their representative may file this petition to request a determination of an employer's responsibility for the payment of compensation related to the employee's occupational disease.

Distribution

The Petition for Award of Compensation – Occupational Disease Law, WCB-160, is to be distributed as follows:

Original — Mail the original petition to the Board at the following address by regular mail:

Workers' Compensation Board
27 State House Station
Augusta, Maine 04333-0027

Copy 1 — Mail one copy of the petition **by certified mail, return receipt requested** to the insurance company or 3rd-party administrator (if there is an insurance company or 3rd-party administrator representing the employer).

Copy 2 — Mail one copy of the petition **by certified mail, return receipt requested** to the employer.

Copy 3 — Keep one copy of the petition for your records. Also keep the green certified mail cards (for the copies sent to the insurance company or 3rd-party administrator and the employer) when the U.S. Post Office returns them to you.

INSTRUCTIONS FOR COMPLETING PETITION FOR AWARD OF COMPENSATION – OCCUPATIONAL DISEASE LAW, WCB-160

Employee

Name

Enter the injured employee's first name, middle initial and last name.

Street/P.O. Box

Enter the injured employee's mailing address.

City, State, Zip
Enter the city, state and zip code of the injured employee's mailing address.

Telephone Number
Enter the injured employee's home telephone number, including the area code.

Employee Social Security Number
Enter the injured employee's social security number.

Board File Number
Enter the jurisdiction claim number assigned by the Board to identify this claim.

Employer

Name
Enter the employer's name.

Street/P.O. Box
Enter the employer's mailing address.

City, State, Zip
Enter the city, state and zip code of the employer's mailing address.

Insurance Company

Name
Enter the name of the insurance company or 3rd-party administrator (if there is one) who represents the employer's interest in this workers' compensation claim.

Street/P.O. Box
Enter the insurance company or 3rd-party administrator's mailing address.

City, State, Zip
Enter the city, state and zip code of the insurance company or 3rd-party administrator's mailing address.

1. On ___/___/____, _____ developed a work-related disease while working for _____.
   MM DD YYYY Employee Name Employer Name
   Enter the date (month, day, year) of the onset of the employee's occupational disease on the first line.
   Enter the injured employee's name (first name, middle initial and last name) on the second line.

   Enter the employer's name on the third line.

2. Date of last exposure: ___/___/____
   MM DD YYYY

   Enter the last date (month, day, year) that the injured employee was exposed to the cause or condition from which the occupational disease arose.

3. Date of Incapacity: ___/___/____
   MM DD YYYY

   Enter the date (month, day, year) of the first day (partial or full) lost from work because of the occupational disease.

4. Date employment ceased: ___/___/____
   MM DD YYYY

   Enter the date (month, day, year) that the injured employee stopped working for the employer listed above.

5. Describe how the exposure occurred:

   Enter a brief description of the events or conditions that caused the employee to be exposed to the cause or condition from which the occupational disease arose.

6. Describe the occupational disease:

   Enter a brief description of the occupational disease (asbestosis, silicosis, occupational hearing loss, etc.).

7. List the body part(s) affected:

   Enter the name(s) of the body part(s) (right eye, left lung, etc.) affected by the occupational disease.

_____
Signature of Employee

This line must be signed by the injured employee or their representative.

Dated: ___/___/____
MM DD YYYY

Enter the date (month, day, year) that this form was signed by the injured employee or their representative.

_____
Name of Employee's Attorney or Advocate (If Any)

If the injured employee is represented by an attorney or advocate, enter the name of the employee's attorney or advocate.

_____
Street/P.O. Box

Enter the attorney or advocate's mailing address.

_____
City, State, Zip

Enter the city, state and zip code of the attorney or advocate's mailing address.

NOTES

PETITION FOR RESTORATION

STATE OF MAINE
WORKERS COMPENSATION BOARD
27 STATE HOUSE STATION
AUGUSTA, MAINE 04333-0027

EMPLOYEE

NAME: _____

STREET/P.O. BOX: _____

CITY, STATE, ZIP: _____

TELEPHONE NUMBER: _____

EMPLOYEE SOCIAL SECURITY NUMBER: _____

BOARD FILE NUMBER: _____
(IF KNOWN)

EMPLOYER

NAME: _____

STREET/P.O. BOX: _____

CITY, STATE, ZIP: _____

INSURANCE COMPANY

NAME: _____

STREET/P.O. BOX: _____

CITY, STATE, ZIP: _____

1. On _____, _____
MONTH DAY YEAR EMPLOYEE NAME

   experienced a work-related injury while working for _____.
EMPLOYER NAME

2. Describe how the injury occurred: _____.

3. List the body part(s) injured:
   _____.

4. Compensation of $_____ per week was paid for
   _____.
PARTIAL/TOTAL INCAPACITY (SELECT ONE)

5. Compensation benefits were_____ as of
   _____.
REDUCED/DISCONTINUED/ (SELECT ONE) MONTH DAY YEAR

6. As of _____, a new period of _____ exists.
MONTH DAY YEAR PARTIAL/TOTAL INCAPACITY (SELECT ONE)

WHEREFORE, the employee asks the Board to order the restoration of the following benefits pursuant to 39-A M.R.S.A. (check all that apply):

_____ Weekly lost time benefits
_____ Specific loss benefits
_____ Other (please specify)_____

_____ DATED: _____
SIGNATURE OF EMPLOYEE MONTH DAY YEAR

FILING INSTRUCTIONS

1. Mail original petition to the Workers= Compensation Board at the above address by regular mail.
2. Mail one (1) copy **by certified mail, return receipt requested** to the insurance company.
3. Mail one (1) copy **by certified mail, return receipt requested** to the employer.
4. Keep one (1) copy for yourself and keep the green certified mail cards when returned to you by the U.S. Post Office.

NAME OF EMPLOYEE'S ATTORNEY OR ADVOCATE (IF ANY)

STREET/P.O. BOX

CITY, STATE, ZIP

THE STATE OF MAINE DOES NOT DISCRIMINATE ON THE BASIS OF DISABILITY IN ADMISSION TO, ACCESS TO, OR OPERATION OF ITS PROGRAMS, SERVICES, OR ACTIVITIES. THIS FORM IS AVAILABLE IN ALTERNATIVE FORMAT. FOR FURTHER ASSISTANCE, CONTACT THE MAINE WORKERS' COMPENSATION BOARD, ADA COORDINATOR, TELEPHONE: 1-888-801-9087 OR TTY (877) 832-5525

PETITION FOR RESTORATION, WCB-170

An injured employee or their representative may file this petition to request a determination of the injured employee's entitlement to restoration of weekly compensation.

Distribution

The Petition for Restoration, WCB-170, is to be distributed as follows:

Original — Mail the original petition to the Board at the following address by regular mail:

Workers' Compensation Board
27 State House Station
Augusta, Maine 04333-0027

Copy 1 — Mail one copy of the petition **by certified mail, return receipt requested** to the insurance company or 3rd-party administrator (if there is an insurance company or 3rd-party administrator representing the employer).

Copy 2 — Mail one copy of the petition **by certified mail, return receipt requested** to the employer.

Copy 3 — Keep one copy of the petition for your records. Also keep the green certified mail cards (for the copies sent to the insurance company or 3rd-party administrator and the employer) when the U.S. Post Office returns them to you.

INSTRUCTIONS FOR COMPLETING PETITION FOR RESTORATION, WCB-170

Employee

Name
Enter the injured employee's first name, middle initial and last name.

Street/P.O. Box
Enter the injured employee's mailing address.

City, State, Zip
Enter the city, state and zip code of the injured employee's mailing address.

Telephone Number
Enter the injured employee's home telephone number, including the area code.

Employee Social Security Number

Enter the injured employee's social security number.

Board File Number

Enter the jurisdiction claim number assigned by the Board to identify this claim.

Employer

Name

Enter the employer's name.

Street/P.O. Box

Enter the employer's mailing address.

City, State, Zip

Enter the city, state and zip code of the employer's mailing address.

Insurance Company

Name

Enter the name of the insurance company or 3rd-party administrator (if there is one) who represents the employer's interest in this workers' compensation claim.

Street/P.O. Box

Enter the insurance company or 3rd-party administrator's mailing address.

City, State, Zip

Enter the city, state and zip code of the insurance company or 3rd-party administrator's mailing address.

1. On ___/___/____, _____ experienced a work-related injury while working for _____.
   MM DD YYYY Employee Name Employer Name

   Enter the date (month, day, year) of the employee's injury on the first line.
   Enter the injured employee's name (first name, middle initial and last name) on the second line.
   Enter the employer's name on the third line.

2. Describe how the injury occurred:

   Enter a brief description of how the injury occurred.

3. List the body part(s) injured:

   Enter a list of the body parts affected by the injury or illness. When specifying a part of the body, be sure to indicate whether it is "left" or "right." When the injury involves fingers or toes, use the numbers one through five to describe the body part. (One is the thumb or big toe; five is the little finger or little toe.)

4. Compensation of $ _____ per week was paid for _____.
   Partial/Total Incapacity (Select One)

   Enter the dollar amount of the weekly workers' compensation benefit last paid to the injured employee on the first line. If the weekly benefit differed from week to week, enter the word "varying" on this line.

   If the amount shown on the first line represents the full amount of benefits allowed for a full week of lost earnings, enter the word "total" on the second line. If the amount shown on the first line does not represent the full amount of benefits allowed for a full week of lost earnings, enter the word "partial" on this line.

5. Compensation benefits were _____ as of ___/___/____.
   Reduced/Discontinued (Select One) MM DD YYYY

   Enter the word (reduced or discontinued) which best describes the last change in the injured employee's weekly benefits on the first line.

   Enter the effective date (month, day, year) of the reduction or discontinuance of weekly benefits on the second line.

6. As of ___/___/____, a new period of _____ exists.
   MM DD YYYY Partial/Total Incapacity (Select One)

   Enter the date (month, day, year) of the onset of the new or increased period of incapacity on the first line.

   Enter the phrase (partial incapacity or total incapacity) which best describes the new or increased period of incapacity on the second line.

WHEREFORE, the employee asks the Board to order the restoration of the following benefits pursuant to 39-A M.R.S.A. (check all that apply):

___ Weekly lost time benefits
___ Specific loss benefits
___ Other (please specify)

Check all lines that represent the restored benefits you are seeking. If you check "Other," enter a brief description of what that benefit is.

_____
Signature of Employee

This line must be signed by the injured employee or their representative.

Dated: ___/___/____
MM DD YYYY

Enter the date (month, day, year) that this form was signed by the injured employee or their representative.

_____
Name of Employee's Attorney or Advocate (If Any)

If the injured employee is represented by an attorney or advocate, enter the name of the employee's attorney or advocate.

_____
Street/P.O. Box

Enter the attorney or advocate's mailing address.

_____
City, State, Zip

Enter the city, state and zip code of the attorney or advocate's mailing address.

NOTES

PETITION FOR REINSTATEMENT

STATE OF MAINE
WORKERS' COMPENSATION BOARD
27 STATE HOUSE STATION
AUGUSTA, MAINE 04333-0027

EMPLOYEE

NAME: _____

STREET/P.O. BOX: _____

CITY, STATE, ZIP: _____

TELEPHONE NUMBER: _____

EMPLOYEE SOCIAL SECURITY NUMBER: _____

BOARD FILE NUMBER: _____
(IF KNOWN)

EMPLOYER

NAME: _____

STREET/P.O. BOX: _____

CITY, STATE, ZIP: _____

INSURANCE COMPANY

NAME: _____

STREET/P.O. BOX:

CITY, STATE, ZIP: _____

1. On _____ (MONTH), _____ (DAY), _____ (YEAR) _____ (EMPLOYEE NAME) experienced a work-related injury while working for _____ (EMPLOYER NAME).

2. List the body part(s) injured : _____

_____

3. On _____ (MONTH), _____ (DAY), _____ (YEAR), I contacted the employer and requested the following (check all that apply):
   _____ Reinstatement to my former position
   _____ Placement in an available position for which I was qualified and physically able to perform

4. On _____ (MONTH), _____ (DAY), _____ (YEAR), the employer denied this request.

WHEREFORE, the employee asks the Board to order the following benefits pursuant to 39-A M.R.S.A. (check all that apply):

_____ Payment of weekly benefits during the period of denial or until I accept other employment and earn a wage in excess of my average weekly wage.

_____ Reinstatement to my former position or any other available position for which I am qualified and physically able to perform.

_____ Other (specify): _____

_____
SIGNATURE OF EMPLOYEE

DATED: _____
MONTH DAY YEAR

FILING INSTRUCTIONS

1. Mail original petition to the Workers= Compensation Board at the above address by regular mail.
2. Mail one (1) copy **by certified mail, return receipt requested** to the insurance company.
3. Mail one (1) copy **by certified mail, return receipt requested** to the employer.
4. Keep one (1) copy for yourself and keep the green certified mail cards when returned to you by the U.S. Post Office.

NAME OF EMPLOYEE'S ATTORNEY OR ADVOCATE (IF ANY)

STREET/P.O. BOX

CITY, STATE, ZIP

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WCB-171 (06/98)

PETITION FOR REINSTATEMENT, WCB-171

An injured employee or their representative may file this petition to request a determination of the injured employee's entitlement to employment at the employer where he/she was injured.

Distribution

The Petition for Reinstatement, WCB-171, is to be distributed as follows:

Original — Mail the original petition to the Board at the following address by regular mail:

Workers' Compensation Board
27 State House Station
Augusta, Maine 04333-0027

Copy 1 — Mail one copy of the petition **by certified mail, return receipt requested** to the insurance company or 3rd-party administrator (if there is an insurance company or 3rd-party administrator representing the employer).

Copy 2 — Mail one copy of the petition **by certified mail, return receipt requested** to the employer.

Copy 3 — Keep one copy of the petition for your records. Also keep the green certified mail cards (for the copies sent to the insurance company or 3rd-party administrator and the employer) when the U.S. Post Office returns them to you.

INSTRUCTIONS FOR COMPLETING PETITION FOR REINSTATEMENT, WCB-171

Employee

Name
Enter the injured employee's first name, middle initial and last name.

Street/P.O. Box
Enter the injured employee's mailing address.

City, State, Zip
Enter the city, state and zip code of the injured employee's mailing address.

Telephone Number
Enter the injured employee's home telephone number, including the area code.

Employee Social Security Number

Enter the injured employee's social security number.

Board File Number

Enter the jurisdiction claim number assigned by the Board to identify this claim.

Employer

Name

Enter the employer's name.

Street/P.O. Box

Enter the employer's mailing address.

City, State, Zip

Enter the city, state and zip code of the employer's mailing address.

Insurance Company

Name

Enter the name of the insurance company or 3rd-party administrator (if there is one) who represents the employer's interest in this workers' compensation claim.

Street/P.O. Box

Enter the insurance company or 3rd-party administrator's mailing address.

City, State, Zip

Enter the city, state and zip code of the insurance company or 3rd-party administrator's mailing address.

1. On ___/___/____, _____ experienced a work-related injury while working for _____.
   MM DD YYYY Employee Name Employer Name

   Enter the date (month, day, year) of the employee's injury on the first line.
   Enter the injured employee's name (first name, middle initial and last name) on the second line.
   Enter the employer's name on the third line.

2. List body part(s) injured:

   Enter a list of the body parts affected by the injury or illness. When specifying a part of the body, be sure to indicate whether it is "left" or "right." When the injury involves fingers or toes, use the numbers one through five to describe the body part. (One is the thumb or big toe; five is the little finger or little toe.)

3. On ___/___/___, I contacted the employer and requested the following (check all that apply):
   MM DD YYYY

   __Reinstatement to my former position

__Placement in an available position for which I was qualified and physically able to perform

Enter the date (month, day, year) that you contacted the employer to request employment on the first line.
If you requested reinstatement to your former position, place a checkmark on the second line.
If you requested another position that you feel you are qualified for and physically able to perform, place a checkmark on the third line.

4. On ___/___/____, the employer denied this request.
MM DD YYYY
Enter the date (month, day, year) that your employer denied your request for re-employment.

WHEREFORE, the employee asks the Board to order the following benefits pursuant to 39-A M.R.S.A. (check all that apply):

___ Payment of weekly benefits during the period of denial or until I accept other employment and earn a wage in excess of my average weekly wage.
___ Reinstatement to my former position or any other available position for which I am qualified and physically able to perform.
___ Other (specify):

If you wish to be paid weekly benefits while you are denied reinstatement or until you are employed elsewhere and earning no less than you did before your injury, place a checkmark on the first line.
If you wish to be re-employed by the employer listed above, place a checkmark on the second line.
If you are seeking something not included on the first two lines, place a checkmark on the third line and provide an explanation.

_____
Signature of Employee
This line must be signed by the injured employee or their representative.

Dated: ___/___/____
MM DD YYYY
Enter the date (month, day, year) that this form was signed by the injured employee or their representative.

_____
Name of Employee's Attorney or Advocate (If Any)
If the injured employee is represented by an attorney or advocate, enter the name of the employee's attorney or advocate.

_____
Street/P.O. Box
Enter the attorney or advocate's mailing address.

City, State, Zip

Enter the city, state and zip code of the attorney or advocate's mailing address.

NOTES

PETITION TO DETERMINE EXTENT OF PERMANENT IMPAIRMENT

STATE OF MAINE
WORKERS' COMPENSATION BOARD
27 STATE HOUSE STATION
AUGUSTA, MAINE 04333-0027

PETITIONER	RESPONDENT
NAME: _____	NAME: _____
STREET/P.O. BOX: _____	STREET/P.O. BOX: _____
CITY, STATE, ZIP: _____	CITY, STATE, ZIP: _____
TELEPHONE NUMBER: _____	RESPONDENT
	NAME: _____
EMPLOYEE SOCIAL SECURITY NUMBER: _____	STREET/P.O. BOX: _____
BOARD FILE NUMBER: _____ (IF KNOWN)	CITY, STATE, ZIP: _____

1. On _____ (MONTH DAY Y EAR), _____ (EMPLOYEE NAME)

   experienced a work-related injury while working for _____ (EMPLOYER NAME).

2. Describe how the injury occurred :

   _____

3. The injury resulted in a permanent impairment to (list body part(s) affected):

   _____

WHEREFORE, the petitioner asks the Board to determine the extent of permanent impairment.

_____
SIGNATURE OF PETITIONER

DATED: _____ (MONTH DAY YEAR)

EMPLOYEE FILING INSTRUCTIONS

1. Mail original petition to the Workers= Compensation Board at the above address by regular mail.
2. Mail one (1) copy **by certified mail, return receipt requested** to the insurance company.
3. Mail one (1) copy **by certified mail, return receipt requested** to the employer.
4. Keep one copy for yourself and keep the green certified mail cards when returned to you by the Post Office.

NAME OF PETITIONER'S ATTORNEY OR ADVOCATE (IF ANY)

STREET/P.O. BOX

CITY, STATE, ZIP

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WCB-180 (06/98)

PETITION TO DETERMINE EXTENT OF PERMANENT IMPAIRMENT, WCB-180

Any interested party may file this petition to request a determination of the extent of an injured employee's permanent impairment.

Use the following distribution requirements only when this form is being prepared and filed by the injured employee or their representative.
(Distribution requirements for the employer or its representative follow the instructions.)

Distribution

The Petition to Determine Extent of Permanent Impairment, WCB-180, is to be distributed as follows:

Original — Mail the original petition to the Board at the following address by regular mail:

Workers' Compensation Board
27 State House Station
Augusta, Maine 04333-0027

Copy 1 — Mail one copy of the petition **by certified mail, return receipt requested** to the insurance company or 3rd-party administrator (if there is an insurance company or 3rd-party administrator representing the employer).

Copy 2 — Mail one copy of the petition **by certified mail, return receipt requested** to the employer.

Copy 3 — Keep one copy of the petition for your records. Also keep the green certified mail cards (for the copies sent to the insurance company or 3rd-party administrator and the employer) when the U.S. Post Office returns them to you.

INSTRUCTIONS FOR COMPLETING PETITION TO DETERMINE EXTENT OF PERMANENT IMPAIRMENT, WCB-180

Petitioner

Name

Enter the injured employee's first name, middle initial and last name.

Street/P.O. Box

Enter the injured employee's mailing address.

City, State, Zip

Enter the city, state and zip code of the injured employee's mailing address.

Telephone Number

Enter the injured employee's home telephone number, including the area code.

Employee Social Security Number

Enter the injured employee's social security number.

Board File Number

Enter the jurisdiction claim number assigned by the Board to identify this claim.

Respondent

Name

Enter the employer's name.

Street/P.O. Box

Enter the employer's mailing address.

City, State, Zip

Enter the city, state and zip code of the employer's mailing address.

Respondent

Name

Enter the name of the insurance company or 3rd-party administrator (if there is one) who represents the employer's interest in this workers' compensation claim.

Street/P.O. Box

Enter the insurance company or 3rd-party administrator's mailing address.

City, State, Zip

Enter the city, state and zip code of the insurance company or 3rd-party administrator's mailing address.

1. On ___/___/____, _____ experienced a work-related injury while working for _____.
   MM DD YYYY Employee Name Employer Name

   Enter the date (month, day, year) of the employee's injury on the first line.
   Enter the injured employee's name (first name, middle initial and last name) on the second line.

   Enter the employer's name on the third line.

2. Describe how the injury occurred:
   Enter a brief description of how the injury happened.

3. The injury resulted in a permanent impairment to (list body part(s) affected):
   Enter a list of the body parts that have been permanently impaired by the injury. When specifying a part of the body, be sure to indicate whether it is "left" or "right." When the injury involves fingers or toes, use the numbers one through five to describe the body part. (One is the thumb or big toe; five is the little finger or little toe.)

_____
Signature of Petitioner

This line must be signed by the injured employee or their representative.

Dated: ___/___/____
MM DD YYYY

Enter the date (month, day, year) that this form was signed by the injured employee or their representative.

_____
Name of Petitioner's Attorney or Advocate (If Any)

If the injured employee is represented by an attorney or advocate, enter the name of the employee's attorney or advocate.

_____
Street/P.O. Box

Enter the attorney or advocate's mailing address.

_____
City, State, Zip

Enter the city, state and zip code of the attorney or advocate's mailing address.

Use the following distribution requirements only when this form is being prepared and filed by the employer, insurer, 3rd-party administrator, or its representative. (Instructions for the employee or their representative precede the instructions.)

Distribution

The Petition to Determine Extent of Permanent Impairment, WCB-180, is to be distributed as follows:

Original	Mail the original petition to the Board at the following address by regular mail: Workers' Compensation Board 27 State House Station Augusta, Maine 04333-0027
Copy 1	Mail one copy of the petition **by certified mail, return receipt requested** to the injured employee.
Copy 2	If this petition is being filed by the insurer, 3rd-party administrator, employer attorney or employer advocate, mail one copy of the petition **by certified mail, return receipt requested** to the employer.
Copy 3	If the employee is represented by an attorney or advocate, mail one copy of the petition **by certified mail, return receipt requested** to the attorney or advocate.
Copy 4	Keep one copy of the petition for your records. Also keep the green certified mail cards (for the copies sent to the employee, employer and the employee's attorney) when the U.S. Post Office returns them to you.

NOTES

PETITION FOR PAYMENT OF MEDICAL AND RELATED SERVICES

STATE OF MAINE
WORKERS' COMPENSATION BOARD
27 STATE HOUSE STATION
AUGUSTA, MAINE 04333-0027

EMPLOYEE	EMPLOYER
NAME: _____	NAME: _____
STREET/P.O. BOX: _____	STREET/P.O. BOX: _____
CITY, STATE, ZIP: _____	CITY, STATE, ZIP: _____
TELEPHONE NUMBER: _____	INSURANCE COMPANY
EMPLOYEE SOCIAL SECURITY NUMBER: _____	NAME:
BOARD FILE NUMBER: _____ (IF KNOWN)	STREET/P.O. BOX:
	CITY, STATE, ZIP:

1. On _____ (MONTH DAY YEAR), _____ (EMPLOYEE NAME)

   experienced a work-related injury while working for _____ (EMPLOYER NAME).
2. Describe how the injury occurred:

   _____
3. List body part(s) injured:

   _____

   _____
4. The charges for medical and related services such as prescriptions and mileage in connection with this injury amount

   to: $_____ (ATTACH COPIES OF ALL BILLS).

WHEREFORE, the employee asks the Board to order payment of the attached work-related medical bills and services pursuant to 39-A M.R.S.A.

_____
SIGNATURE OF EMPLOYEE

DATED: _____
MONTH DAY YEAR

FILING INSTRUCTIONS

1. Mail original petition to the Workers= Compensation Board at the above address by regular mail.
2. Mail one (1) copy **by certified mail, return receipt requested** to the insurance company.
3. Mail one (1) copy **by certified mail, return receipt requested** to the employer.
4. Keep one (1) copy for yourself and keep the green certified mail cards when returned to you by the U.S. Post Office.

NAME OF EMPLOYEE=S ATTORNEY OR ADVOCATE (IF ANY)

STREET/P.O. BOX

CITY, STATE, ZIP

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WCB-190 (06/98)

PETITION FOR PAYMENT OF MEDICAL AND RELATED SERVICES, WCB-190

An injured employee or their representative may file this petition to request a determination of the injured employee's entitlement to payment of medical and related services arising from the work-related injury.

Distribution

The Petition for Payment of Medical and Related Services, WCB-190, is to be distributed as follows:

Original — Mail the original petition to the Board at the following address by regular mail:

Workers' Compensation Board
27 State House Station
Augusta, Maine 04333-0027

Copy 1 — Mail one copy of the petition **by certified mail, return receipt requested** to the insurance company or 3rd-party administrator (if there is an insurance company or 3rd-party administrator representing the employer).

Copy 2 — Mail one copy of the petition **by certified mail, return receipt requested** to the employer.

Copy 3 — Keep one copy of the petition for your records. Also keep the green certified mail cards (for the copies sent to the insurance company or 3rd-party administrator and the employer) when the U.S. Post Office returns them to you.

INSTRUCTIONS FOR COMPLETING PETITION FOR PAYMENT OF MEDICAL AND RELATED SERVICES, WCB-190

Employee

Name

Enter the injured employee's first name, middle initial and last name.

Street/P.O. Box

Enter the injured employee's mailing address.

City, State, Zip
Enter the city, state and zip code of the injured employee's mailing address.

Telephone Number
Enter the injured employee's home telephone number, including the area code.

Employee Social Security Number
Enter the injured employee's social security number.

Board File Number
Enter the jurisdiction claim number assigned by the Board to identify this claim.

Employer

Name
Enter the employer's name.

Street/P.O. Box
Enter the employer's mailing address.

City, State, Zip
Enter the city, state and zip code of the employer's mailing address.

Insurance Company

Name
Enter the name of the insurance company or 3rd-party administrator (if there is one) who represents the employer's interest in this workers' compensation claim.

Street/P.O. Box
Enter the insurance company or 3rd-party administrator's mailing address.

City, State, Zip
Enter the city, state and zip code of the insurance company or 3rd-party administrator's mailing address.

1. On ___/___/____, _____ experienced a work-related injury while working for _____.
   MM DD YYYY Employee Name Employer Name
   Enter the date (month, day, year) of the employee's injury on the first line.
   Enter the injured employee's name (first name, middle initial and last name) on the second line.
   Enter the employer's name on the third line.

2. Describe how the injury occurred:
   Enter a brief description of how the injury occurred.

3. List body part(s) injured:

   Enter a list of the body parts affected by the injury or illness. When specifying a part of the body, be sure to indicate whether it is "left" or "right." When the injury involves fingers or toes, use the numbers one through five to describe the body part. (One is the thumb or big toe; five is the little finger or little toe.)

4. The charges for medical and related services such as prescriptions and mileage in connection with this injury amount to: $_____.
   Attach Copies of All Bills

   Enter the dollar value of all unpaid medical bills and related charges (prescription, mileage, etc.). Be sure to attach copies of all unpaid bills.

_____
Signature of Employee

This line must be signed by the injured employee or their representative.

Dated: ___/___/____
MM DD YYYY

Enter the date (month, day, year) that this form was signed by the injured employee or their representative.

_____
Name of Employee's Attorney or Advocate (If Any)

If the injured employee is represented by an attorney or advocate, enter the name of the employee's attorney or advocate.

_____
Street/P.O. Box

Enter the attorney or advocate's mailing address.

_____
City, State, Zip

Enter the city, state and zip code of the attorney or advocate's mailing address.

NOTES

PROVIDER'S PETITION FOR PAYMENT OF MEDICAL AND RELATED SERVICES

STATE OF MAINE
WORKERS' COMPENSATION BOARD
27 STATE HOUSE STATION
AUGUSTA, MAINE 04333-0027

HEALTH CARE PROVIDER

NAME: _____

STREET/P.O. BOX:

CITY, STATE, ZIP: _____

TELEPHONE NUMBER: _____

EMPLOYEE NAME:

EMPLOYEE SOCIAL SECURITY NUMBER: _____

DATE OF INJURY:

BOARD FILE NUMBER: _____
(IF KNOWN)

EMPLOYER

NAME:

STREET/P.O. BOX: _____

CITY, STATE, ZIP:

INSURANCE COMPANY

NAME:

STREET/P.O. BOX:

CITY, STATE, ZIP:

1. On _____, _____
MONTH DAY Y EAR EMPLOYEE NAME

experienced a work-related injury while working for _____.
EMPLOYER NAME

2. The charges for medical and related services in connection with this injury amount to: $_____.
ATTACH COPIES OF ALL BILLS

WHEREFORE, the health care provider asks the Board to order payment of the attached work-related medical bills and services pursuant to 39-A M.R.S.A.

_____
SIGNATURE OF HEALTH CARE REPRESENTATIVE

DATED: _____
MONTH DAY YEAR

FILING INSTRUCTIONS

1. Mail original petition to the Workers= Compensation Board at the above address by regular mail.
2. Mail one (1) copy **by certified mail, return receipt requested** to the insurance company.
3. Mail one (1) copy **by certified mail, return receipt requested** to the employer.
4. Keep one (1) copy for yourself and keep the green certified mail cards when returned to you by the U.S. Post Office.

NAME OF PROVIDER'S ATTORNEY (IF ANY)

STREET/P.O. BOX

CITY, STATE, ZIP

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WCB-190A (06/98)

PROVIDER'S PETITION FOR PAYMENT OF MEDICAL AND RELATED SERVICES, WCB-190A

A healthcare provider or their representative may file this petition to request a determination of an injured employee's entitlement to payment of medical and related services arising from their work-related injury.

Distribution

The Provider's Petition for Payment of Medical and Related Services, WCB-190A, is to be distributed as follows:

Original — Mail the original petition to the Board at the following address by regular mail:

Workers' Compensation Board
27 State House Station
Augusta, Maine 04333-0027

Copy 1 — Mail one copy of the petition **by certified mail, return receipt requested** to the insurance company or 3rd-party administrator (if there is an insurance company or 3rd-party administrator representing the employer).

Copy 2 — Mail one copy of the petition **by certified mail, return receipt requested** to the employer.

Copy 3 — Keep one copy of the petition for your records. Also keep the green certified mail cards (for the copies sent to the insurance company or 3rd-party administrator and the employer) when the U.S. Post Office returns them to you.

INSTRUCTIONS FOR COMPLETING PROVIDER'S PETITION FOR PAYMENT OF MEDICAL AND RELATED SERVICES, WCB-190A

Health Care Provider

Name

Enter the healthcare provider's name.

Street/P.O. Box:

Enter the healthcare provider's mailing address.

City, State, Zip:
Enter the city, state and zip code of the healthcare provider's mailing address.

Telephone Number
Enter the healthcare provider's business telephone number, including the area code.

Employee Name:
Enter the injured employee's first name, middle initial and last name.

Employee Social Security Number
Enter the injured employee's social security number.

Date of Injury:
Enter the injured employee's date of injury (month, day, year).

Board File Number
Enter the jurisdiction claim number assigned by the Board to identify this claim.

Employer

Name
Enter the employer's name.

Street/P.O. Box
Enter the employer's mailing address.

City, State, Zip
Enter the city, state and zip code of the employer's mailing address.

Insurance Company

Name
Enter the name of the insurance company or 3rd-party administrator (if there is one) who represents the employer's interest in this workers' compensation claim.

Street/P.O. Box
Enter the insurance company or 3rd-party administrator's mailing address.

City, State, Zip
Enter the city, state and zip code of the insurance company or 3rd-party administrator's mailing address.

1. On ___/___/____, _____ experienced a work-related injury while working for _____.
   MM DD YYYY Employee Name Employer Name
   Enter the date (month, day, year) of the employee's injury on the first line.
   Enter the injured employee's name (first name, middle initial and last name) on the second line.
   Enter the employer's name on the third line.

2. The charges for medical and related services in connection with this injury amount to: $_____.
   Attach Copies of All Bills
   Enter the dollar value of all unpaid charges for medical and related services arising from the aforementioned employee's work-related injury.

_____
Signature of Health Care Representative
This line must be signed by the healthcare provider or their representative.

Dated: ___/___/____
MM DD YYYY
Enter the date (month, day, year) that this form was signed by the healthcare provider or their representative.

_____
Name of Employee's Attorney or Advocate (If Any)
If the healthcare provider is represented by an attorney or advocate, enter the name of the healthcare provider's attorney or advocate.

_____
Street/P.O. Box
Enter the attorney or advocate's mailing address.

_____
City, State, Zip
Enter the city, state and zip code of the attorney or advocate's mailing address.

NOTES

PETITION TO REMEDY DISCRIMINATION

STATE OF MAINE
WORKERS' COMPENSATION BOARD
27 STATE HOUSE STATION
AUGUSTA, MAINE 04333-0027

EMPLOYEE	EMPLOYER
NAME: _____	NAME: _____
STREET/P.O. BOX: _____	STREET/P.O. BOX: _____
CITY, STATE, ZIP: _____	CITY, STATE, ZIP: _____
TELEPHONE NUMBER: _____	
EMPLOYEE SOCIAL SECURITY NUMBER: _____	
BOARD FILE NUMBER: _____ (IF KNOWN)	

1. The above-named employer discriminated against me as a result of a work-related injury on: _____. (MONTH DAY YEAR)
2. Explain how the employer discriminated:

_____

WHEREFORE, the employee asks the Board to order the following benefits pursuant to 39-A M.R.S.A. ∋353 (check all that apply):

_____ Back wages
_____ Reinstatement to my former position or any other available position for which I am qualified and physically able to perform
_____ Reestablishment of my employee benefits
_____ Payment of reasonable attorney fees

_____
SIGNATURE OF EMPLOYEE

DATED: _____
MONTH DAY YEAR

FILING INSTRUCTIONS

1. Mail original petition to the Workers= Compensation Board at the above address by regular mail.
2. Mail one (1) copy **by certified mail, return receipt requested** to the insurance company.
3. Mail one (1) copy **by certified mail, return receipt requested** to the employer.
4. Keep one (1) copy for yourself and keep the green certified mail cards when returned to you by the U.S. Post Office.

NAME OF EMPLOYEE'S ATTORNEY OR ADVOCATE (IF ANY)

STREET/.P.O. BOX

CITY, STATE, ZIP

THE STATE OF MAINE DOES NOT DISCRIMINATE ON THE BASIS OF DISABILITY IN ADMISSION TO, ACCESS TO, OR OPERATION OF ITS PROGRAMS, SERVICES, OR ACTIVITIES. THIS FORM IS AVAILABLE IN ALTERNATIVE FORMAT. FOR FURTHER ASSISTANCE, CONTACT THE MAINE WORKERS' COMPENSATION BOARD, ADA COORDINATOR, TELEPHONE: 1-888-801-9087 OR TTY (877) 832-5525

WCB-195 (06/98)

PETITION TO REMEDY DISCRIMINATION, WCB-195

An injured employee or their representative may file this petition to request a determination regarding allegations of discrimination against the employee by the employer because of a work-related injury.

Distribution

The Petition to Remedy Discrimination, WCB-195, is to be distributed as follows:

Original — Mail the original petition to the Board at the following address by regular mail:

Workers' Compensation Board
27 State House Station
Augusta, Maine 04333-0027

Copy 1 — Mail one copy of the petition **by certified mail, return receipt requested** to the insurance company or 3rd-party administrator (if there is an insurance company or 3rd-party administrator representing the employer).

Copy 2 — Mail one copy of the petition **by certified mail, return receipt requested** to the employer.

Copy 3 — Keep one copy of the petition for your records. Also keep the green certified mail cards (for the copies sent to the insurance company or 3rd-party administrator and the employer) when the U.S. Post Office returns them to you.

INSTRUCTIONS FOR COMPLETING PETITION TO REMEDY DISCRIMINATION, WCB-195

Employee

Name
Enter the injured employee's first name, middle initial and last name.

Street/P.O. Box
Enter the injured employee's mailing address.

City, State, Zip
Enter the city, state and zip code of the injured employee's mailing address.

Telephone Number

Enter the injured employee's home telephone number, including the area code.

Employee Social Security Number

Enter the injured employee's social security number.

Board File Number

Enter the jurisdiction claim number assigned by the Board to identify this claim.

Employer

Name

Enter the employer's name.

Street/P.O. Box

Enter the employer's mailing address.

City, State, Zip

Enter the city, state and zip code of the employer's mailing address.

1. The above-named employer discriminated against me as a result of a work-related injury on: ___/___/____
   MM DD YYYY

   Enter the date (month, day, year) of the work-related injury.

2. Explain how the employer discriminated:

   Enter a brief description of the employer's discriminatory action(s) against the injured employee.

WHEREFORE, the employee asks the Board to order the following benefits pursuant to 39-A M.R.S.A. §353 (check all that apply):

___ Back wages
___ Reinstatement to my former position or any other available position for which I am qualified and physically able to perform
___ Reestablishment of my employee benefits
___ Payment of reasonable attorney fees

Place a checkmark on all lines that describe the remedies for discrimination that you are seeking.

_____
Signature of Employee

This line must be signed by the injured employee or their representative.

Dated: ___/___/____
MM DD YYYY

Enter the date (month, day, year) that this form was signed by the injured employee or their representative.

_____
Name of Employee's Attorney or Advocate (If Any)

If the injured employee is represented by an attorney or advocate, enter the name of the employee's attorney or advocate.

_____
Street/P.O. Box

Enter the attorney or advocate's mailing address.

_____
City, State, Zip

Enter the city, state and zip code of the attorney or advocate's mailing address.